

Examining Regional Variation In Commercial Prices For Shoppable Services And Projected Savings From Reference Pricing

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Abstract: In prior issue briefs, we've examined how changes in utilization and patient characteristics contribute to spending growth, but we've yet to explore the role of prices. A growing number of states are adopting policies to address high commercial prices, though these policies are often narrowly targeted at state employee plans, thereby limiting aggregate savings. We use 2024 fully insured commercial market data from California's Health Care Payments Database to examine regional price variation for 70 health care services the Centers for Medicare and Medicaid Services (CMS) has designated as shoppable and then estimate potential savings under a reference pricing policy. For many of the most common shoppable services, we find that the difference in price between the 10th and the 90th percentile can vary by a factor of ten or more within the same region. Under a counterfactual in which shoppable services with above-median prices were instead reimbursed at the median within-region price, commercial spending would decrease by approximately \$1.3 billion (3 percent of total commercial claims spending). We've also made the datasets documenting regional variation and projected savings at the Current Procedural Terminology (CPT) code level publicly available on OHCA's website. These findings and datasets can inform health plans, purchasers, and state policymakers seeking strategies to rein in commercial price variation and reduce aggregate spending.

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Key points

- Shoppable services – services that can be scheduled in advance, are routinely provided in non-urgent settings, and where quality does not meaningfully vary – represent more than 9% of claims spending in California’s fully insured commercial market.
- There’s substantial regional variation in the prices for shoppable services, as measured by the difference between the 10th and 90th price percentiles. The Northern counties region (22 counties) has the highest average price variation with a ratio of 90th to 10th percentile varying between 1.67 to 84.5. For region-specific variation for each Current Procedural Terminology code (CPT), see online appendix table 1.
- By introducing regional reference pricing for shoppable services, aggregate spending in the fully insured commercial market would decrease by \$1.3 billion or 34.7% of current levels. For savings estimates for each CPT code, see online appendix table 2.

Background

At the June 2026 California Health Care Affordability Board meeting, the Office of Health Care Affordability (OHCA) reported on health care spending growth in California from 2023 and 2024 (hereafter referred to as forthcoming interim report).¹ The forthcoming interim report contains regional analysis of commercial claims and capitation spending per person per year. In 2023, it shows variation in commercial spending across regions from \$5,645 (Kern County) to \$8,673 (San Mateo County) per person per year with even higher spending variation in 2024 (\$5,831 to \$9,477). In general, Northern and Central California regions have higher spending levels than Southern or Eastern California regions. Moreover, the forthcoming report documents significant variation in 2023-2024 spending growth across regions, ranging from 2.2% (Eastern counties) to 13.0% (Alameda County). But the aggregated nature of OHCA’s data collection is ill-equipped to examine within-region variation, nor can it speak to the extent to which prices contribute to variation in spending levels.

In this analysis, we build upon the analysis in OHCA’s forthcoming interim report using claims data to analyze both within- and between-region price variation for a subset of healthcare services in the commercial market. More specifically, we look at variation in the Centers for Medicare and Medicaid Services’ (CMS) list of shoppable services among fully insured commercial enrollees within Covered California regions in 2024 and calculate potential savings from regional reference pricing for these services.

Methods

CMS defines shoppable services as non-emergency services that can be scheduled by a healthcare consumer in advance. CMS provides a list of 70 shoppable services (74 codes), 5 codes representing inpatient procedures (5 Diagnostic-Related Groups, DRG) and the rest are outpatient (69 CPT or HCPCS codes). See appendix tables for the full list of shoppable services codes and categories.

We use commercial market claims from California-based providers for calendar year 2024 from California's Health Care Payments database (HPD). We exclude encounters under capitation payment arrangements and any claims that are attributed to CalPERS members since CalPERS has reference pricing on some procedures. If shoppable services are administered in an emergency room or patients were admitted in an emergency, we exclude these claims from the shoppable categories, but we keep those claims for the purposes of calculating statewide claims spending.

To minimize the effect of outliers for shoppable services, we first exclude claims with negative or \$0 allowed amounts for shoppable services and then drop any claims that are below the 1st percentile and above the 99th percentile on shoppable procedures or DRG-level statewide.

We construct a service-region-year level dataset and calculated the median, 10th, 25th, 75th and 90th percentiles of allowed amounts within regions for each service. Region is defined based on the Covered California regions representing a county or group of counties in the state.²

We calculate total statewide spending within the commercial market, excluding claims for CalPERS members and encounters under capitation arrangements and outliers in shoppable services.

For each shoppable service, we calculated its share of statewide claims spending by summing up all allowed amounts for that service across the state and dividing by statewide claims spend. For each category of shoppable services, we aggregate services within each category by summing up their shares in total statewide spending.

To calculate potential savings from reference pricing, we first calculate total spending on the service within the region as is and then we calculate total spending but with the price capped at the regional median level. By using regional medians rather than average allowed amounts, we further minimize the effect of outliers. We define savings from reference pricing as the difference between the two spending measures in dollars and also report it as a share of statewide total spending.

Findings

Price Variation

To illustrate price variation for the same service within and across regions, we plot the distribution of allowed amounts for five services in two regions. The list of services includes 1) computed tomography (CT) scan of abdomen and pelvis with contrast (CPT 74177), 2) colonoscopy with biopsy (CPT 45380), 3) mammogram, bilateral, with CAD (CPT 77067), 4) magnetic resonance imaging (MRI) of the brain (CPT 70553) and 5) cesarian delivery (CPT 59510). We chose one Northern California region (Sacramento) and one Southern California region (Los Angeles East). The Greater Sacramento region includes Sacramento, Placer, El Dorado and Yolo counties; the Los Angeles East (LA East) region includes the east side of the Los Angeles County.

Figures 1 through 5 show the variation in allowed amounts for a specific procedure. For example, Figure 1 shows that the median allowed amount for colonoscopy with biopsy (CPT 45380) in the Sacramento region is \$1,112, with prices varying between \$20 and \$7,000. For cesarian delivery (Figure 2), the median allowed amount in the LA East region is \$2,550, with prices ranging between \$1,500 and \$10,000.

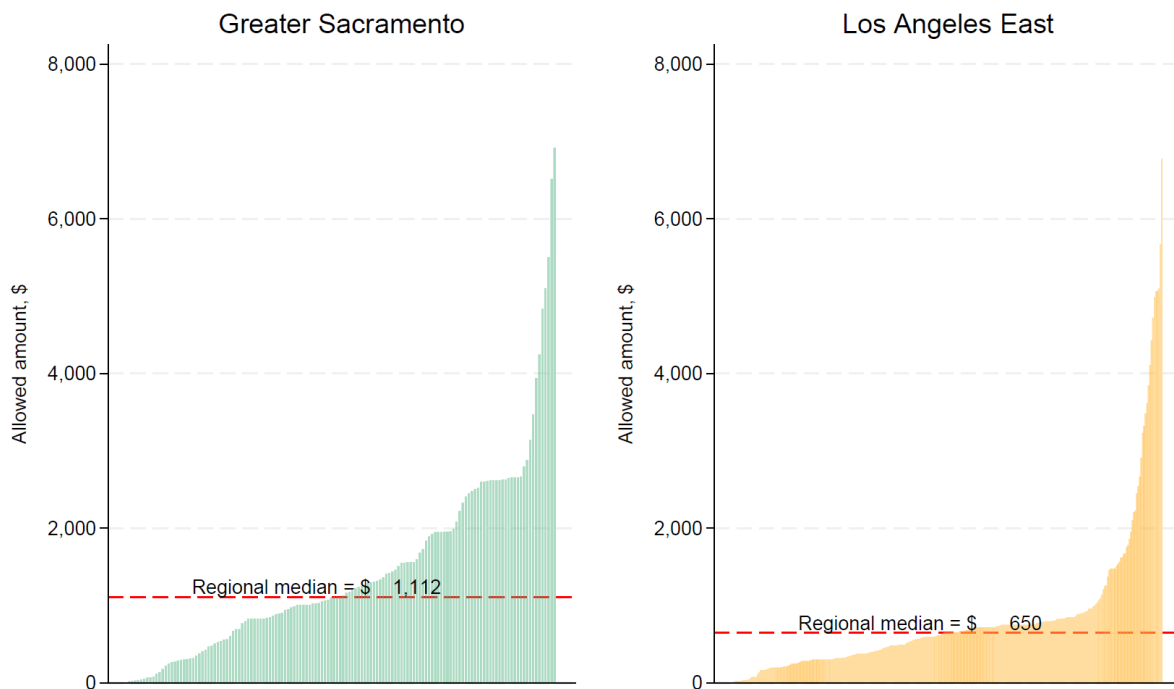
Overall, while price ranges are similar, the Sacramento region shows higher median allowed amounts than the LA East region. For example, for MRI (Figure 3), the median price in the Sacramento region is \$1,749, while in the LA East region, the median is \$474. For CT scan of the abdomen and pelvis with contrast (Figure 4), in the Sacramento region, the median price is \$2,324, more than two times the median price of \$941 in the LA East region. The median price of a mammogram in Sacramento (Figure 5) is \$424, almost three times the median price of \$159 in the LA East region.

A full set of 70 services across all 19 regions with allowed amount percentiles and a measure of variation is in Online Appendix Table 1. We use a ratio of 90th percentile to 10th percentile, P90/P10 ratio, to measure variation in allowed amounts: a ratio of 10 means that the 90th percentile allowed amount is 10 times larger than the 10th percentile.

Online Appendix Table 1 documents substantial variation within each region. The highest average variation (average P90/P10 ratio of 19) is documented for Covered California region 1 (Northern counties) that includes 22 counties with ratios varying between 1.67 (CPT 90847 Family psychotherapy) and 84.5 (CPT 70450 CT head/brain without contrast). The lowest average variation (average P90/P10 ratio of 8.9) is in Covered California region 5 (Contra Costa County) with ratios between 1.33 (CPT 76805 Ultrasound pregnancy first trimester) and 52.6 (CPT 85610 Blood test, clotting time).

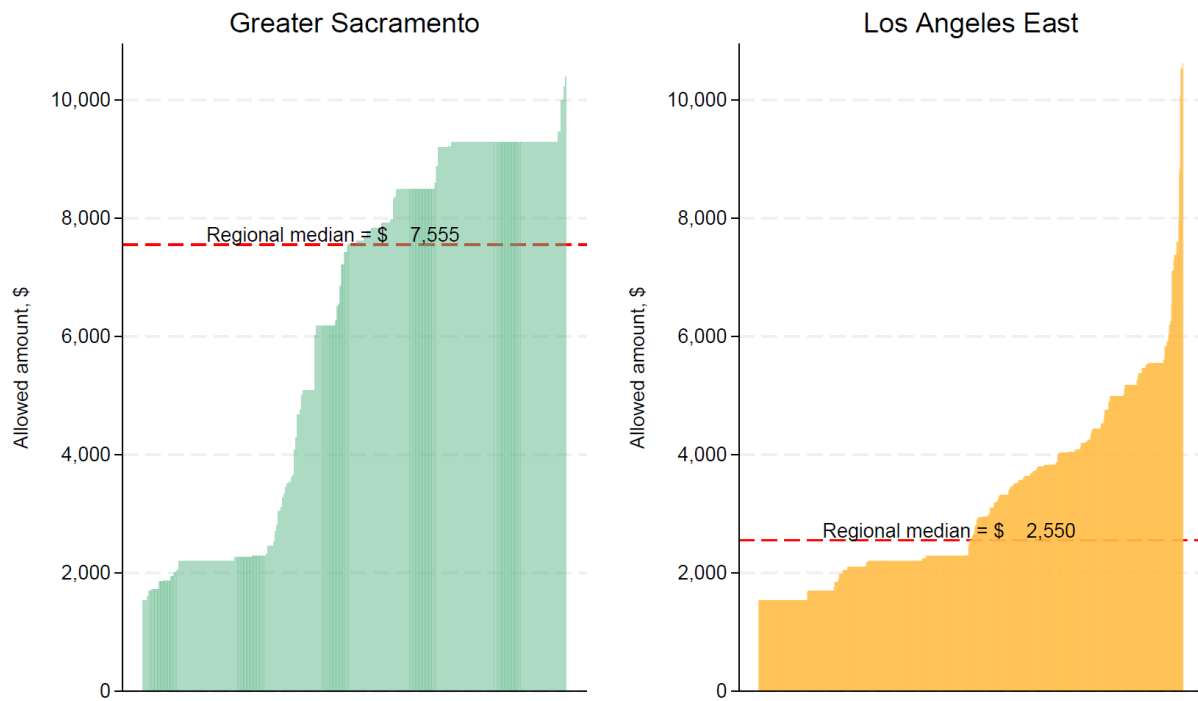
Overall, all shoppable services represented almost \$4 billion (9.19%) in total statewide claims spending in the fully insured commercial market in 2024 (Table 1). The largest category of shoppable services was “Evaluation and management services” with \$1.6 billion (3.83% of total statewide claims spending), followed by “Medicine and surgery services” with \$1.3 billion (2.95%), Radiology services with \$720.8 million (1.68%) and Laboratory and pathology services with \$299.7 million (0.70%). Given the substantial variation in the prices for shoppable services within regions and its share of claims spending, the use of reference pricing could produce significant savings for consumers, which we explore in the next section.

Figure 1. Colonoscopy with biopsy (CPT 45380)



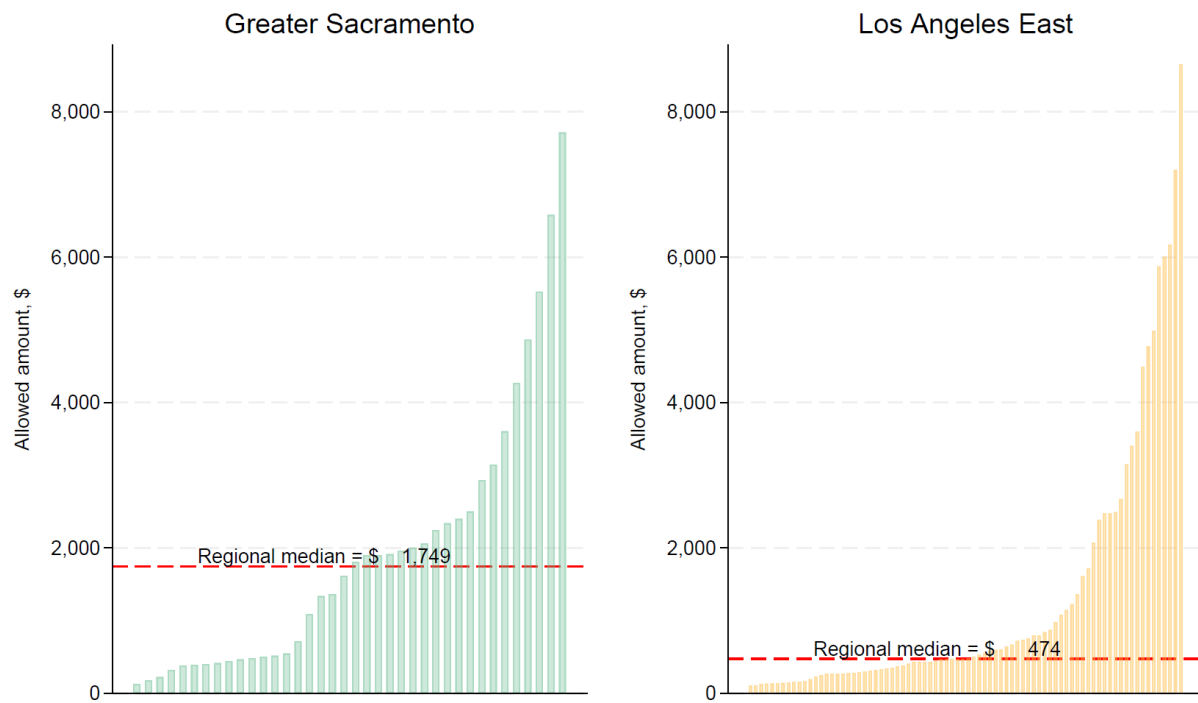
Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in the Methods section. X-axis represents individual claims (or set of 50 claims) ordered by allowed amount in ascending order. Red dashed line represents regional median allowed amount. Claims with allowed amounts below 1st percentile and above 99th percentile statewide allowed amount are excluded.

Figure 2. Cesarean delivery (CPT 59510)



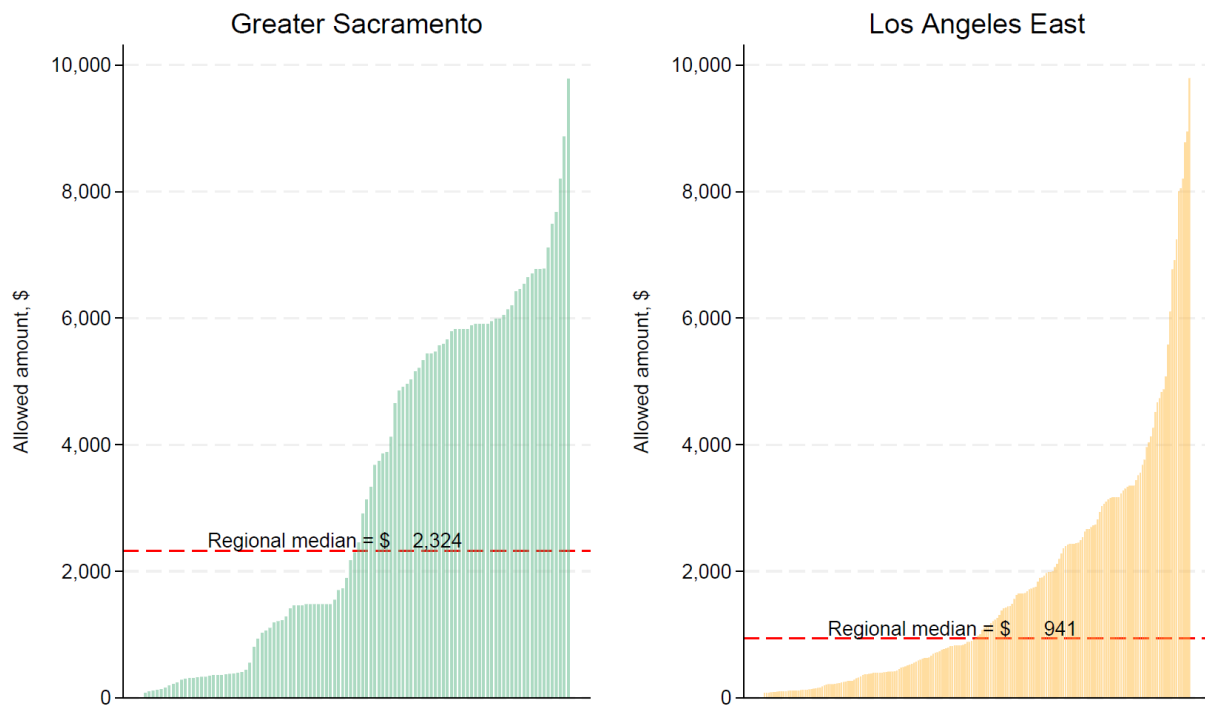
Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in the Methods section. X-axis represents individual claims (or set of 50 claims) ordered by allowed amount in ascending order. Red dashed line represents regional median allowed amount. Claims with allowed amounts below 1st percentile and above 99th percentile statewide allowed amount are excluded.

Figure 3. MRI of the brain (CPT 70553)



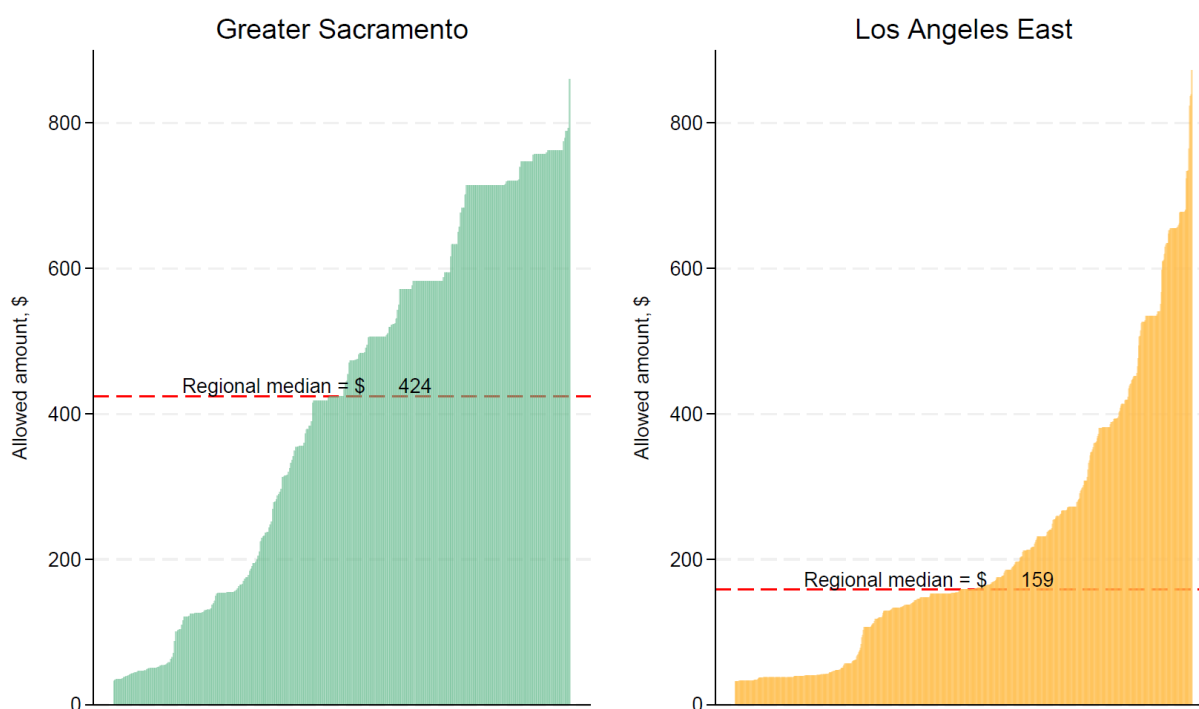
Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in the Methods section. X-axis represents individual claims (or set of 50 claims) ordered by allowed amount in ascending order. Red dashed line represents regional median allowed amount. Claims with allowed amounts below 1st percentile and above 99th percentile statewide allowed amount are excluded.

Figure 4. CT scan of abdomen and pelvis with contrast (CPT 74177)



Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in the Methods section. X-axis represents individual claims (or set of 50 claims) ordered by allowed amount in ascending order. Red dashed line represents regional median allowed amount. Claims with allowed amounts below 1st percentile and above 99th percentile statewide allowed amount are excluded.

Figure 5. Mammogram, bilateral, with CAD (CPT 77067)



Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in Methods sections. X-axis represents individual claims (or set of 50 claims) ordered by allowed amount in ascending order. Red dashed line represents regional median allowed amount. Claims with allowed amounts below 1st percentile and above 99th percentile statewide allowed amount are excluded.

Projected Savings from Reference Pricing

Reference pricing policies have been used across European countries and U.S. states to reduce price variation. Typically, an employer or insurer will set a reference price for a service or procedure (e.g., \$30,000 for an elective total knee replacement) and only provide reimbursement at or below that reference price. If a consumer were to seek care at locations with services priced above the reference price, the consumer is responsible for the difference between the reference price and the provider's price, and that difference does not count toward the consumer's deductible or out-of-pocket maximum.

Evaluations have found that reference pricing policies increase patients' use of low-price facilities, reduce use of high-price facilities, reduce prices at high-price inpatient hospitals without negative health outcomes and generated cost savings for employers.³

In our setting, a reference price could be adopted wherein each shoppable service is capped at the regional median allowed amount; doing so would generate \$1.3 billion in savings, or 34.7% of spending on shoppable services (Table 1). Across categories,

“Medicine and surgery services” services would generate \$523 million in savings, followed by “Radiology services” with \$365 million in savings. In terms of statewide claims spending, median caps on shoppable services would reduce spending by 3.18%.

We’d note that the use of regional medians as the basis for the reference price necessarily limits the extent of savings compared to approaches that cap provider prices based on a single standard, such as a percentage of Medicare or the statewide median.

Table 1. Saving from reference pricing by shoppable services category

Shoppable category	2024 Statewide Claims spending by shoppable category, millions \$	2024 Statewide Claims spending capped at median regional allowed amounts by shop, millions \$	Savings, millions \$	Savings, % of category spending	Savings, % of statewide claim spending	Share in statewide spending, %
Evaluation and management services	\$1,644.9 M	\$1,350.5 M	\$294.5 M	17.90%	0.69%	3.83%
Laboratory and pathology services	\$299.7 M	\$119.9 M	\$179.7 M	59.97%	0.42%	0.70%
Medicine and surgery services	\$1,266.8 M	\$743.7 M	\$523.1 M	41.29%	1.22%	2.95%
Radiology services	\$720.8 M	\$354.9 M	\$365.9 M	50.76%	0.85%	1.68%
Total	\$3,932.2 M	\$2,569.0 M	\$1,363.2 M	34.7%	3.18%	9.19%

Notes: Data from HPD for calendar year 2024 excludes capitation, CalPERS members and other exclusions as mentioned in the Methods section. Calculations are outlined in the Methods section. Projected savings for all 70 shoppable procedures are included in Online Appendix Table 2.

Discussion

In this brief, we documented substantial price variation for shoppable services within regions – in some instances reaching more than 10 times between the first and the last decile. Similar findings for California are reported across multiple studies. CalPERS, for example, documented price variation across counties for common procedures like MRI and EKG and noted that composite overall prices vary across California by 82%.⁴ Cooper et al. (2018) use claims data for patients covered by employer-sponsored insurance to document variation in prices for common procedures across hospitals in California.⁵

Price variation is observed not only in California, but in other states as well. The Health Policy Commission in Massachusetts reported relative price variation for common procedures across providers in 2021.⁶ A growing body of literature has analyzed negotiated prices released under CMS’s Transparency in Coverage (TiC) requirement with researchers documenting regional, state and even within-hospital variation in prices for the same procedure.^{7,8} Other research has found that online posted negotiated

prices are different from both the chargemasters and the offered cash prices and thus posted online prices are less useful for consumers.^{9,10} While consumer use of shoppable tools has been modest, research has found that price transparency could lead to decreasing prices in one market and increasing prices in others.^{11,12}

In a 2025 report, the Massachusetts Center for Health Information and Analysis (CHIA) highlighted that the providers in the most expensive quartile account for more than 45% of total spending. Additionally, CHIA reported variation in relative prices by type of hospital (from 8% below the statewide average relative price for community hospitals to 12% above statewide average for academic medical centers).¹³

To address price variation, several states and state agencies have implemented reference pricing to varying degrees. The California Public Employees' Retirement System (CalPERS), the agency that manages health benefits for active and retired public employees, has used reference pricing for several procedures since 2011, including total joint replacement, colonoscopy, arthroscopy, and cataract surgery. CalPERS uses a statewide reference price for a procedure and has preferred providers (e.g., ambulatory surgery centers over hospital outpatient departments). This policy seeks to steer consumers to lower-price providers for elective services that vary in price but not in quality.

In contrast to more modest reference pricing policies, some states have implemented more far-reaching regulatory reforms to address high prices. Rhode Island, for example, adopted hospital price growth caps in 2010 for the fully insured commercial market, which led to an average 9 percent reduction in hospital prices as well as reductions in premiums for that market.¹⁴ Using data up to 2016, Baum and coauthors showed that with the introduction of price growth caps, spending growth in Rhode Island has slowed without any adverse effects on quality.¹⁵

After introducing reference pricing for state employees' health plans in 2016, Montana saved \$47.8 million in combined inpatient and outpatient spending from 2017-2019.¹⁶

In 2019, Oregon introduced caps on hospitals prices for state employees using Medicare rates as the reference price. The cap reduced hospital inpatient prices per admission by \$900-\$2,770 and hospital outpatient prices by approximately \$130 per procedure. Overall, it saved approximately 4% of total state employees' plan spending (~\$107 million).¹⁷

With examples from various states in mind, there are several proposals to use reference pricing on a larger scale to address commercial prices and realize consumer and budget savings.¹⁸ A proposal by the Committee for a Responsible Federal Budget estimates between \$30 billion to \$110 billion in federal budget savings with an additional

\$15-\$50 billion in employee savings if referenced pricing is implemented for the Federal Employee Health Benefits (FEHB) program.¹⁹

Similarly, in this brief we explored potential savings from introducing reference pricing for shoppable services using regional median allowed amounts. This reference pricing could be implemented by health plans and purchasers through market-based mechanisms, or policymakers through regulatory reforms. The projected savings could reach \$1.3 billion in a single year, or 3% of statewide claims spending, which is comparable to nationwide proposals.²⁰

Limitations

This analysis has several limitations. First, the reliability of our findings is constrained by limitations inherent in the data sources. California's Department of Health Care Access and Information (HCAI) continues to work with submitters on improving data quality in the Health Care Payments database (HPD). Potential errors in payer databases may introduce measurement error and contribute to the findings. Despite these concerns, HPD represents the best available source for examining claim-level healthcare costs and utilization in California.

Second, we only analyze the fully insured commercial market, which in turn means the projected savings described above are likely to constitute a lower bound.

Third, we exclude capitated services. With Kaiser representing more than 41% of California's commercial market enrollment, our analysis thus excludes a significant proportion of the market.²¹

Fourth, our calculation of the impact of capping services does not take into account potential actions by providers that have below-median allowed amounts who could respond by increasing their prices, negating some of the savings described here.¹²

Fifth, in this brief we use the regional median allowed amount in 2024 as an option for the reference price. Setting reference prices in absolute values could require a complementary policy design feature to allow those caps to be periodically adjusted to keep pace with the cost of delivering care.

Conclusion

We documented substantial variation in the prices of shoppable services – services that should not meaningfully vary in quality – within and across California regions. These services represent almost \$4 billion in spending (~9% of statewide claims-based spending) in 2024 alone. If California health plans and purchasers through market-based mechanisms, or policymakers through regulatory reforms, were to adopt reference pricing for shoppable services across the fully insured commercial market,

consumers could save up to \$1.3 billion on these procedures in a single year (~3% of statewide spending). Additionally, we made datasets with regional price variation and potential savings at the CPT code level available on the OHCA website for any interested parties.

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Appendix

Data

We used 2024 commercial claims from the Healthcare Payment Database Quarterly Extract 15008 published on February 27, 2026. We excluded encounters with capitation arrangements, claims with \$0 and negative allowed amounts, and claims for CalPERS members.

We limited our sample to rendering providers with addresses in California, excluding duplicated and denied claims. Covered California region was assigned based on the zip code of the rendering provider.

From shoppable procedures, we excluded procedures rendered in an emergency room (for CPTs) and procedures via an emergency admission (for DRGs); however, those services were kept for the calculation of the total statewide claims-based spending. If the procedure was provided as a part of an inpatient stay for a shoppable DRG, it's included into the DRG calculation.

Additionally, from shoppable procedures, we exclude outliers that are below the 1st percentile or above the 99th percentile statewide allowed amounts. To calculate spending by shoppable DRG, we sum up all spending for each inpatient stay and apply trimming based on the DRG-inpatient stay level.

We calculate statewide spending for each shoppable procedure and category by summing up all allowed amounts by and across regions.

Within each region, we calculate the median, 10th, 25th, 75th and 90th percentile by allowed amounts. We calculate projected spending levels when prices for these shoppable procedures are capped at regional median levels and then calculate savings by subtracting projected spending from actual spending for each procedure. We aggregate savings across regions to the statewide level by procedure and calculate savings as a percent of actual spending and percent of statewide spending.

Supplemental material

Available on the OHCA website - <https://hcai.ca.gov/document/online-appendices-for-the-ohca-september-2026-issue-brief/>

Online Appendix Table 1. Price Variation for shoppable services by region

Online Appendix Table 2. Savings from reference pricing by shoppable services