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April 22, 2025

How a New Bill Could Address NY's Spiraling Healthcare Costs

Key Findings

- New York State legislators have the opportunity to address private sector healthcare affordability by passing the Fair Pricing Act (S.705/A.2140).
- The act would address the root cause of rising healthcare costs by regulating hospital prices, which are the key driver of spiraling healthcare inflation.
- Rising healthcare costs have placed a growing burden on families and businesses in New York, with the average individual premium up 76 percent since 2010.
- A recent study suggests that the Fair Pricing Act could lower healthcare costs by $1.14 billion in New York State, with $120.9 million in savings for the New York City public employee benefits program and $71.9 million in savings for New York State employees.

Introduction

Affordability is on the agenda in Albany, with advocates and legislators proposing ways to help working-class New Yorkers address the rising costs of housing and childcare. Yet the legislature has failed to address healthcare affordability, which would require taking on the rising cost and declining quality of employer-sponsored insurance (ESI). The cost of ESI has skyrocketed in New York and nationally in the past several years, with the average individual health insurance premium up nearly 76 percent since 2010, to $9,200. Family premiums have risen even more dramatically, by 79 percent; the average family premium is now $26,355.[1] As costs have increased, employers have shifted costs to workers by raising the deductibles on healthcare plans, to the point where New Yorkers must pay on average nearly $2,000 out of pocket before their insurance kicks in.

New York now has a crucial opportunity to address this problem by passing the Fair Pricing Act (S.705/A.2140). This act would begin to address the root causes of healthcare inflation by regulating the price of some forms of outpatient hospital care.

[1] MEPS-IC data, https://datatools.ahrq.gov/meps-ic/

Healthcare Affordability in the Commercial Insurance Market

When New York politicians talk about healthcare costs, they generally focus on Medicaid. Medicaid, after all, is the largest single item in the state budget, and together with Child Health Plus it covers 5.2 million New Yorkers, over 26 percent of the total population.[2] Less often discussed is employer-sponsored insurance. Yet employer-sponsored insurance remains the largest single source of insurance coverage for New Yorkers, covering 47 percent of state residents as of 2023 – down slightly from 51 percent in 2010, according to ACS data.[3]

And ESI costs have risen dramatically – by over 75 percent in New York since 2010. The rapidly rising cost of employer-sponsored insurance impacts both businesses and households, since premium costs are split between employers and employees, with employers typically paying about 80 percent of premiums for an individual plan and 72 percent of premiums for a family plan in New York – around $7,300 per employee for an individual plan and $19,000 for a family plan in 2023. Employers have responded to these costs by offering lower-quality insurance plans which cover less than they used to. One way to measure this is through rising deductibles – the dollar amount employees must pay out of pocket before insurance kicks in. Deductibles have roughly doubled in New York since 2010, from $891 to $1,722 for an individual policy and $1,728 to $3,672 for a family policy. And these are just averages – workers with lower-quality insurance, who are typically lower-income, can face deductibles in the $4,000 range for an individual plan. Unsurprisingly, most working-class people can't afford to pay thousands of dollars out of pocket for care, so decreasing insurance quality leaves them unable to access care and burdens them with medical debt when they do seek treatment.

To the extent that New York policymakers have sought to address this issue in recent years, they have focused on regulating *insurance,* requiring insurance policies to cover some categories of healthcare with low or no out-of-pocket costs. For example, New York last year passed legislation requiring insurance to cover insulin with no copays.[4]

This policy approach is of limited use for two reasons. First, states are restricted by federal rules in their ability to regulate insurance. Two thirds of people enrolled in ESI in New York are in self-insured plans, which are governed by the federal Employee Retirement Income Security Act (ERISA); the state is forbidden by federal law from regulating these plans. Thus, only one-third of the New Yorkers enrolled in commercial insurance will actually be helped by laws like the insulin bill.

Second, regulating insurance coverage does not address the root cause of declining insurance quality, which is healthcare cost inflation. Insurance is getting worse because costs are rising, and someone must pay the price; limiting out-of-pocket costs for some beneficiaries will force employers to raise premiums for others. That doesn't mean it's a bad idea – a system where everyone pays a little

[2] These figures include Medicaid and CHIP for non-dual enrollees but exclude dual-eligible Medicaid enrollees (who receive primary coverage from Medicare) as well as Essential Plan enrollees and Emergency Medicaid registrants.
[3] https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=14&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[4] https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=14&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

more is indeed preferable to a system where people with diabetes are forced to pay out the nose for insulin – but to fully address the issue we need to address healthcare inflation.

Addressing the Root Cause: Hospital Price Inflation

But the root cause of rising healthcare costs is the price paid by private insurers to providers – particularly hospitals, which consume 37 percent of healthcare spending.[5] And, while New York can't interfere with many private insurance plans, the State *can* regulate the prices charged by New York hospitals. The state can save employers and employees money by regulating what providers charge, effectively controlling prices to stave off healthcare inflation.

There are many reasons to believe that regulating hospital prices would improve healthcare costs with little risk of undermining care. For example, hospital prices have risen far more quickly than inflation, and bear no discernible relation to costs.[6] They are negotiated between insurance companies and hospitals on a secret basis and vary wildly from facility to facility. A recent city report found that the rate the city pays for a colonoscopy varies by more than a factor of four depending on what hospital performs the procedure – from $2,123 at Lenox Hill Hospital to $9,149 at New York Presbyterian.[7] Clearly, with such wide variation in prices for the same exact procedure, these prices are not driven by the cost of care.

So, why do prices vary so widely? The answer is market power. The hospital industry has become increasingly consolidated in recent decades, with large health systems purchasing smaller hospitals and physician practices; as a result, the largest and most prestigious hospital systems have enormous leverage over insurers. That means that if the insurer wants to do business with them, they can insist on high prices and the insurer will have little choice but to agree. These hospital systems use their leverage to increase prices on insurers – and those price increases ultimately lead to higher premiums for employers and higher out-of-pocket costs for workers.

Finding a Solution to High Costs: Site-Neutral Payments

Many outpatient healthcare services can be provided either in a doctor's office or in a hospital outpatient department. For example, a patient may get an echocardiogram, undergo a minor dermatological procedure or simply get a checkup in either setting. One particularly egregious instance of irrational hospital pricing is the fact that these procedures are often vastly more expensive when performed in a hospital outpatient setting than when performed in a doctor's office. Even when the procedure is identical, the hospital can simply charge more, often by adding a "facility fee" to the bill.

This is an issue not only in the commercial insurance market but also in Medicare. In fact, Medicare advocates – including the federal government's own Medicare payment advisory committee, MedPAC – have been recommending for years that Medicare institute "site-neutral payment" rules for some simple procedures, requiring that Medicare reimburse them equally regardless of whether they are performed at a doctor's office or an outpatient clinic.

[5] National Health Expenditure Accounts, 2023.
[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC7517591/
[7] https://www.nyc.gov/assets/doh/downloads/pdf/about/local-law-78-healthcare-accountability-report.pdf

Of course, some procedures that can be performed in an outpatient hospital setting or a non-hospital setting are more safely delivered in a hospital. But for many routine services – preventive screenings, basic x-rays, etc. – the setting makes little difference to the quality of the care. It can make a substantial difference in price, however: A study from Brown University found that a routine chest x-ray that costs just $65.59 in a doctor's office could cost an average of $241.35 in a hospital.

The issue has gained significance as hospitals have expanded in part by purchasing a growing number of outpatient facilities and doctor's offices. The trend is visible in New York City, where health systems like New York-Presbyterian, NYU Langone and Northwell have acquired a vast network of outpatient facilities. In some cases, prices can rise dramatically after a hospital acquires a clinic, simply because it is now owned by a hospital and can bill hospital outpatient rates rather than doctor's office rates. One recent study showed that the percentage of physicians employed by hospitals rose from 25.8 percent nationwide in 2012 to 52.1 percent in 2022.[8]

The fight for site-neutral payment in Medicare is ongoing. Congress enacted a minor reform in 2015, but more comprehensive proposals have met with opposition from the hospital industry and have so far failed to pass. The stakes are high, as the most ambitious proposals could offer $100 billion in savings for Medicare over the next 10 years.[9]

Site-Neutrality in the Private Sector

The same issue exists in the domain of employer-sponsored insurance, but it has received far less attention. While Medicare spending is closely watched by policy wonks because it impacts the federal budget, employer insurance spending is less studied. Outpatient procedures cost far more when performed at a hospital-affiliated provider than when performed in a doctor's office, even for simple and low-risk procedures. As a growing number of independent practices have been purchased by hospital systems, these costs have increased.

The Fair Pricing Act would target these costs by capping prices for some simple procedures at 150% of the rate Medicare would pay a physician for the same services. (Medicare rates are adjusted regionally, so linking spending to Medicare takes regional variations into account.) Whether a procedure is performed at a hospital or at a doctor's office, the price cap would be the same – preventing hospitals from charging excessive rates for procedures that can be performed cheaply and safely in a doctor's office.

How large a price cut would this represent? For non-hospital providers, it would involve no price decrease at all. But for many hospitals, reductions would be substantial. For procedures that can be safely performed in either an ambulatory surgery center (ASC) or a hospital, the Brown study found that ASCs currently charge just 130% of the Medicare rate, while hospitals charge 178%. For procedures that can be safely performed in either a doctor's office or a hospital outpatient setting, the difference is even starker: Doctor's offices charge on average just 132% of the Medicare rate, while hospital settings charge an extraordinary 371%.

[8] https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3D%3D

[9] https://www.kff.org/medicare/issue-brief/five-things-to-know-about-medicare-site-neutral-payment-reforms/

Figure 1: Hospital outpatient vs. doctor's office charges.

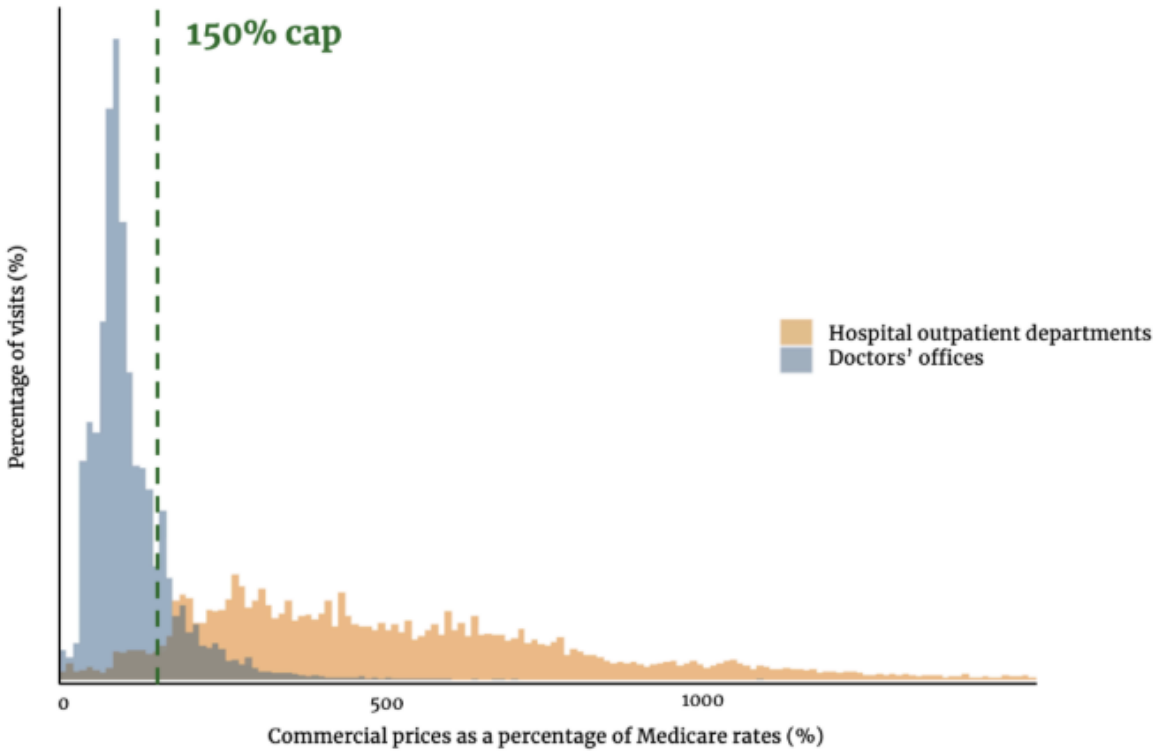

Figure taken from Murry, Roslyn et al., "Estimating Savings from the Fair Pricing Act and Commercial Site-Neutral Payments in New York State.[10]

The Fair Pricing Act price cap would apply only to a specified list of routine procedures that experts at MedPAC have found can be performed safely in a non-hospital setting. Because of this limited scope, savings would be modest overall: Perhaps 2 percent of total health spending by commercial payers in New York. Still, even such modest savings would have represented $1.14 billion less in spending across all commercially insured patients in 2022 – saving around $200 million in out-of-pocket costs to individual patients and lowering premium growth, all by simply aligning prices more closely with costs.

Because public employers—such as New York City and New York State—are major purchasers of healthcare on behalf of their employees, they would also see substantial savings. The same study from Brown University shows that New York City would have saved $120.9 million in employee health benefit costs if the Fair Pricing Act had been in place in 2022, and New York State would have saved an additional $71.9 million. At a moment when rising benefit costs are squeezing public budgets in New York City, such savings would be welcome.

[10] https://drive.google.com/file/d/1ByF77uAu7vRLO8VQ9zH0iCwv_WV3jVaa/view

Fairer Hospital Pricing Will Help Safety Net Hospitals

Predictably, the hospital industry has already begun to push back against this proposal. Industry lobbyists argue that cutting prices paid to hospitals makes little sense when many hospitals across New York are facing closure due to underfunding and are further threatened by looming federal cuts.

Such arguments do not hold up to scrutiny, however. The Fair Pricing Act specifically exempts safety net hospitals from price caps; even if it did not, such hospitals typically see few commercially insured patients and are paid relatively low rates by commercial insurers, so they would not feel much impact from price caps. Wealthy health systems serving mainly commercial patients would absorb the majority of the impact – but these systems, which have brought in hundreds of millions of dollars in net income in the past two years, can well afford to be paid less. NYU Langone, for example, which brought in $235 million in net income in the last three months of its 2024 fiscal year alone, should have no problem adapting to a more rational pricing system for outpatient treatments.[11]

In fact, addressing the irrationalities of healthcare pricing would benefit safety net hospitals, which get paid far less than other hospitals for care. While the Fair Pricing Act would not directly increase safety net funding, it represents a first step towards addressing funding gaps. As the Community Service Society has recently pointed out, hospital price deregulation in 1996 drove hospital closures.[12]

Conclusion

The Fair Pricing Act is an important step in the right direction, exerting public control over medical inflation and addressing one of the most glaring irrationalities in our healthcare spending. Some will argue that New York should avoid regulating hospital prices when federal cuts threaten to upend our healthcare system. In fact, the opposite is true: With federal instability looming, the state can ill afford to permit bloated and wasteful payment structures which raise healthcare costs for everyone and put pressure on city and state budgets. The Fair Pricing Act represents a relatively modest step towards addressing healthcare inflation, applying as it does to only a small share of total healthcare spending – but first steps are important. The legislature should pass the bill this year and initiate a broader discussion of healthcare price regulation.

[11] https://www.crainsnewyork.com/health-pulse/nyu-langone-hospitals-notched-wide-profit-margin-fourth-quarter
[12] https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/NYS_Health_Care_Affordability_February_2025.pdf