FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

The Honorable Liz Krueger
Chair, Finance Committee
New York State Senate
Albany, NY 12247

The Honorable J. Gary Pretlow
Chair, Ways and Means Committee
New York State Assembly
Albany, NY 12247

February 11, 2025

Re: Joint Legislative Public Hearing on 2025 Executive Budget Proposal: Topic Health/Medicaid

Dear Chairs Krueger and Pretlow:

On behalf of Families USA, a leading national, nonpartisan voice for health care consumers, we write today to express our strong support for *the Fair Pricing Act (S.705/A.2140).* For more than 40 years, Families USA has been working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. The Fair Pricing Act is a landmark bill that would provide needed relief from high health care costs to millions of families and individuals across New York, and would save $1.5 billion annually in state health care spending by establishing a fair price for routine services, regardless of where they are delivered.[1] As federal policymakers are debating the possibility of making dangerous cuts to federal funding of health care programs, which would threaten state budgets, members of the New York State Senate Finance Committee and the Assembly Ways and Means Committee have the opportunity to enact bipartisan and evidence-based legislation that will provide billions of dollars in savings without attacking access to health care. *The Fair Pricing Act* is essential to realizing a health system that holds the health care industry accountable for delivering affordable and accessible health care for all New Yorkers.

A Health Care System in Crisis Nationwide

The United States health care system is in crisis, evidenced by a nationwide lack of affordability and poor quality.[2] At its core, this crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer. These high and irrational prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to push our nation's families to the brink of financial ruin.[3]

Across the U.S., Americans report struggling to manage health care expenses and keep up with rising costs.[4] An estimated 72.2 million – or nearly one in three – American adults did not seek needed care in the prior three months due to cost and an estimated 13 million Americans know a friend or family member who died in the past year after not receiving a treatment because they could not afford it.[5] When people in the U.S. do seek care, they are frequently burdened with unmanageable costs and are often forced to choose between basic necessities and paying their health care bills. Over 40% of U.S. adults – 100 million people – face medical debt and nearly one

third report that the high cost of health care interferes with their ability to secure basic needs like food and housing.[6]

High and rising health care costs are also a critical problem for national and state governments and affect the economic vitality of middle-class and working families by crippling the ability of working people to earn a living wage. State and local governments are significant purchasers of health insurance, providing benefits to millions of public employees across the country. As health care costs rise, so do the costs that states and other employers have to incur to provide benefits to employees and retirees. For states and localities, this means a strain on already tight public budgets. For private employers, increasingly hefty contributions to health insurance come at the sacrifice of increasing wages and other benefits. For example, rising health care costs are a major reason why today's real wages (wages after accounting for inflation) are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[7] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[8]

Notably, the excessive cost of health care does not buy Americans higher quality care or even higher volumes of care. In fact, the opposite is true. Despite spending two to three times more on health care than other industrialized countries, the United States has some of the worst health outcomes,[9] including some of the lowest life expectancy and highest infant mortality rates.[10] These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[11,12]

Impact on New Yorkers

As Americans across the United States experience a severe health care affordability and quality crisis, so do New Yorkers. New York has the highest health insurance prices in the country, with residents paying nearly $9,000 a year on average for single, private employer-sponsored insurance – 18% higher than the national average.[13] As is the case across the U.S., high and rising hospital prices are a major driver of these higher and higher health care costs and increased spending. Between 2007 and 2020, New York hospital prices grew 7 times faster than worker's paychecks.[14] Now, New York's per capita hospital spending is $5,500 – 43% higher than the national average of $3,885 and 22% higher than only a decade ago – demonstrating an alarming trend in hospital pricing.[15,16]

As a result of high hospital prices, millions of New Yorkers across the state are forced to choose between their health and their financial security. Surveys show that most New Yorkers are concerned they will not be able to pay for usual health care services and four out of 10 report they or a family member are sacrificing health care due to the cost.[17] One-third of New Yorkers have faced significant financial hardship due to medical costs they couldn't afford, with some reporting being unable to pay for food or housing, racking up large amounts of credit card debt, or having to declare bankruptcy.[18] Unfortunately, out-of-pocket costs are only half the story: while New York consumers struggle to pay their medical bills, their salaries are being increasingly suppressed as employers become unable to keep pace with the cost of providing health insurance benefits.[19]

The budgets of New York State and its residents are becoming increasingly strained as high prices lead to higher public spending on health benefit programs for state and city employees. In 2021, New York State spent $10.3 billion providing health benefits to public employees and retirees, nearly half of which ($4.2 billion) was spent on hospital services.[20] In 2022, New York City spent $8.8 billion providing health benefits to the over 600,000 public employees and retirees.[21] As high hospital prices drive up the cost of city and state employee health benefits, total employee compensation goes down, as does the total budget for public services.[22]

The Role of Site of Service Payment Differences in Driving Hospital Consolidation and High Prices

The Fair Pricing Act addresses the problem of high and rising health care prices by targeting a key driver: site of service payment differentials. Most Americans would be surprised to know that simply because of the legal definition of where care is delivered, the price for that care can vary significantly – regardless of the safety or clinical effectiveness of the site of care. Most Americans experience these hospital pricing abuses as astronomical and mysterious "facility fees" that are added to hospital bills and routinely increase costs for consumers by hundreds or even thousands of dollars.[23,24]

These payment differentials – or site-specific payment differences – are problematic for two key reasons:

1. They incentivize large hospital corporations and health systems to drive care delivery to higher-cost sites, particularly from physician's offices to hospital outpatient departments (HOPDs).
2. They incentivize hospitals to buy up doctors' offices and rebrand them as HOPDs to generate the higher payments.[25]

Importantly, large hospital corporations leverage the broken incentives created by these payment differentials to sustain their business model: purchase hospitals and doctors' offices to become large corporate health care systems that increase prices year after year and maximize service volumes for the highest-priced services.[26] As discussed below in greater detail, these broken incentives are at odds with the goal of ensuring America's families receive the affordable, high-quality care and improved health they deserve.

Under the current hospital payment system, Medicare pays higher rates for medical services performed in HOPDs and other provider-based outpatient facilities than for the same services performed in a physician's office or ambulatory surgical center (ASC).[27,28] Because Medicare sets the benchmark for how other payers reimburse for health care, typically as a percentage of Medicare (e.g., 138% of Medicare), this payment distortion extends into the commercial market. For privately insured patients, hospitals charge higher prices than independent physicians' offices or other outpatient facilities for the same services. This results in patients being billed substantially more for routine care.[29]

In addition to these higher prices, hospitals add "facility fees" for routine services that are often provided in hospital-branded departments.[30] The ability to charge more for hospital care, whether in Medicare or the commercial market, based solely on the site where care is delivered, creates a strong financial incentive for hospitals to consolidate and absorb local competition by buying physician offices and rebranding them as off-campus HOPDs and facilities so they can receive higher payments.[31] The drive toward higher-cost care sites has a direct negative financial impact on the 176 million privately insured Americans across the country, including more than 13 million New Yorkers who rely on private insurance for health care, as well as Medicare beneficiaries and overall Medicare expenditures.[32,33]

Over the past decade, more and more former independent physician practices have become affiliated with major hospital systems. Between 2013 and 2021, the percentage of hospital-owned physician practices rose from 15% to 26% and the percentage of physicians employed by a hospital rose from 27% to 52%.[34] This vertical integration between hospitals and physicians leads to a growing anticompetitive market in which hospitals increase market power. As a result, they can demand higher prices for all consumers including those with private health coverage, where vertical physician-hospital integration can result in price increases of as much as 14% for a single service.[35,36,37] In other words, site-specific payment differences not only allow providers to charge more, they create an additional incentive for further health care consolidation which is in and of itself a driver of higher health care costs.

Researchers have identified significant shifts from physician offices to HOPDs for services such as chemotherapy administration, even though they can be provided in a physician's office at a lower cost with the same quality and safety of care. Nationally, between 2012 and 2019, the share of chemotherapy administration services delivered in hospital outpatient settings increased from 35% to 51%.[38] Moreover, employers and unions providing health insurance in New York are paying an estimated 250% more than Medicare pays for the same hospital services, whereas 35 years ago prices paid to hospitals by commercial insurers were only 10% higher than Medicare rates.[39] Even more alarming are the differences in prices for services delivered at an independent doctor's office versus an HOPD, despite no variation in quality or the service itself. Claims data from the 32BJ Health Fund show an average aggregate cost of $23 for flu shot administration in the doctor's office compared to $183 in the hospital outpatient department – nearly a 700% price increase for a service that takes mere minutes to complete regardless of the site of delivery.[40]

As corporate hospital systems have consolidated, it has become increasingly difficult for commercial payers, unions, and employers to negotiate lower prices. Additionally, as major systems continue to buy up local doctor's offices, clinics, and ambulatory surgical centers, patients have lost choice, often being forced to receive their services from a higher cost HOPD setting. In 2016, 29% of CT scans provided to 32BJ Health Fund participants were delivered in the HOPD setting, by 2022, 41% of those same scans were conducted in the HOPD setting.[41] Patients are often unaware that their provider has been bought by a hospital and now bills as a HOPD, resulting in facility fees or higher payments for services they are used to getting at a much lower cost.[42]

While some services need to be delivered in a hospital setting to ensure the health and safety of patients, numerous routine services – such as MRIs, drug administration, vaccine administration, and gynecological exams – have been determined to be safe and effective if delivered in a traditional doctor's office. The nonpartisan experts at the Medicare Payment Advisory Commission (MedPAC) have issued clear recommendations that aligning payments for services that can safely and effectively be delivered in all settings would address underlying payment distortions and lower health care costs for families across the United States.[43]

Because Medicare payment policy often establishes a standard adopted by other public and private payers, the broken payment incentives in Medicare payment are amplified across payers including in New York.[44,45] Ultimately, the financial incentives created by site-specific payment differentials encourage hospitals to buy up local competition to increase prices and shift care to higher cost care settings. The result is lower wages and higher copays, premiums and cost sharing for America's families and individuals.[46,47]

The Fair Pricing Act

Corporate hospital systems have too long exploited health care pricing rules to line their pockets at the expense of families across New York and the rest of the country. By aligning payment rates for a set of routine services that can be safely and effectively delivered in all health care settings to 150% of the Medicare rate, *the Fair Pricing Act* is set to significantly reduce wasteful health care spending and mitigate a key financial incentive for hospital consolidation. *The Fair Pricing Act* ties payment rates to Medicare rates which continue to adjust over time based on resource use, input costs, and other economic factors and account for regional variation in cost-of-living. By excluding services delivered in the inpatient or emergency room setting, the bill acknowledges the high costs associated with hospital care while establishing a fair price for routine services.

By ensuring that consumers are paying the same price for the same routine service no matter the setting, ***the Fair Pricing Act*** **could save New York an estimated $1.5 billion per year in state health care spending,**[48] providing much needed relief to families across the state. It is because of this that **Families USA strongly supports *the Fair Pricing Act (S.705/A.2140)*** as introduced by Senator Krueger. This first of its kind state site neutral payment legislation marks a significant step in efforts to slow decades of unsustainable health care cost growth and ensure consumers can afford the care they need to reach their best health. By passing t*he Fair Pricing Act,* New York would be the first state to ensure consumers pay the same fair price for routine services regardless of where they received the care. New York would demonstrate national leadership in taking on growing corporate interests in health care and signaling to the rest of the country that commonsense reforms to rein in growing and exorbitant health care costs are possible. The journey to fully transform our health care system is long, but states like New York hold essential power to lead the way and take significant steps forward.

Conclusion

This past November, voters in New York and around the country made it clear that economic and financial security were a priority for them. **Now, as polling reports that 89% of New York voters support *the Fair Pricing Act,*[49] Families USA is excited to stand with New York stakeholders and support the passage of the first state price cap for routine outpatient services.**

Thank you again for your work to improve health care affordability for families across New York. As federal actions continue to sow uncertainty and threaten the economic security of our nation's families, there is no better time to take steps in New York to protect consumers from irrationally high and growing health care prices. Families USA stands ready to support as you continue this critical work. For further information, please contact Jane Sheehan, Deputy Senior Director of Government Relations at Families USA (JSheehan@familiesusa.org).

Sincerely,

Sophia Tripoli, MPH
Senior Director of Health Policy

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