



HOW THE

Fair Pricing Act's Site Neutral Policy

Boosts Health Care Affordability

BY ENSURING SAVINGS WILL BE PASSED THROUGH TO PATIENTS AND PAYERS

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Executive Summary

New York State has the dubious distinction of ranking second in the nation for highest health care expenditures and health insurance premiums. Rising hospital prices are a primary driver of these high costs. Many states have adopted major policy reforms designed to control health care costs, including: establishing independent regulatory entities; adopting statewide global budgets; and enacting reference-based pricing mechanisms.

One modest proposal to abate the steep incline in health care prices is a policy known as site neutral reform, which seeks to align prices and insurance reimbursement for procedures regardless of the setting in which they are delivered. In 2015, Congress passed legislation mandating site neutral payments in Medicare for most new off-campus clinics, a provision recently expanded through federal rulemaking.

New York legislation called the Fair Pricing Act (S705A (Krueger)|A2140 (Jackson)) proposes to establish a site neutral policy at the State level. The Act would cap payments for a small set of routine services at a set percentage above the Medicare payment rate for commercial and public payers. A Brown University study found that the Fair Pricing Act would result in \$1.1 billion in health care savings and directly reduce out-of-pocket costs for New York patients by \$213 million a year.

Some stakeholders have expressed concern that the enactment of the Fair Pricing Act would enrich insurance carriers at the expense of an already distressed hospital industry. This brief explains how the existing insurance regulatory infrastructure prevents insurance carriers from retaining savings achieved through the Fair Pricing Act and how these savings would be passed on to patients.

Background

Health care spending has increased rapidly over the past several decades in New York and across the country. Between 2000 and 2020, national per capita hospital spending increased by 162 percent, and health care costs rose approximately twice as fast as the rate of inflation. In New York, hospital spending increased even faster—203 percent over the same period.¹

It is well established that prices, as opposed to patient care, utilization, or complexity of services used, drive rising health care spending.²

Specifically, rising hospital prices have had the largest impact, with hospital spending making up more than one third of all health care expenditures in New York.³ Patients, unions, employers, and insurance companies are left to absorb rising payments to providers through higher insurance claims.⁴ Estimates suggest that a 1 percent increase in health care prices leads to a 0.95 percent increase in employer-sponsored health insurance premiums, leading employers to lower wages and/or reduce their number of employees.⁵ Importantly, higher hospital

prices are not necessarily associated with a corresponding increase in quality of care and may actually be associated with *lower* hospital performance and patient experience scores.⁶

States have implemented a variety of policy options to address high hospital prices. California has established an Office of Health Care Affordability, which is responsible for establishing and overseeing a cost growth benchmark that limits how much health care providers can increase prices year over year.⁷

In Maryland, hospital global budgets are designed to incentivize efficient spending, prevent unnecessary hospitalizations, and stabilize hospital budgets.⁸ Several states—Colorado, Oregon, Washington, and Vermont—employ reference-based pricing or price caps to align hospital prices more closely to costs.⁹ Other states, including New York, from the 1960s to the mid-1990s, have leveraged all-payer rate setting models to control costs, aid financially distressed hospitals, and help uninsured individuals access care.¹⁰

Site Neutral: A Modest Proposal to Control Hospital Price Inflation

A significant driver of rising health care spending is the recent shift from providing routine care at doctors' offices to hospital-owned outpatient departments (HOPDs) that charge substantially higher prices.¹¹

This phenomenon is problematic for two reasons. First, it incentivizes hospitals and health systems to drive the delivery of routine care to higher-cost sites, like HOPDs. Second, it incentivizes hospitals to acquire doctors' offices and rebrand them as HOPDs to charge higher prices at a larger scale.¹² This results in higher costs for patients and insurers through increased out-of-pocket costs and higher premiums.¹³

Nationally, Medicare provides a model to align payments across sites of care. In 2015, the Bipartisan Budget Act (BBA) established site neutral payments for services received at off-campus HOPDs. However, this bill included

notable exemptions including grandfathering of existing off-campus HOPDs and excluding on-campus HOPDs.¹⁴ As a result, less than one percent of all HOPD spending is for services covered by the BBA of 2015 requirements.¹⁵ In November 2025, the Centers for Medicare and Medicaid Services (CMS) released a rule that expanded site neutral policies to drug administration services provided in off-campus HOPDs.¹⁶ The Medicare Payment Advisory Commission (MedPAC) has advocated for site neutral payments for a select group of low-complexity medical services that can be safely performed in non-hospital settings since 2014.¹⁷

Medicare-based payment policies offer a model for state policy action to contain health care costs for everyone else not covered by Medicare, such as people with employer-based and public insurance.



New York’s Fair Pricing Act

New York policymakers have an opportunity to regulate hospital prices and curb the rapid growth of health care spending through the Fair Pricing Act (S705A/A2140). The Act would cap prices at 150 percent of the Medicare rate for the set of routine services identified by MedPAC that can be safely performed in non-hospital settings.¹⁸

Currently, prices for routine services differ considerably depending on the site of care. For example, a new patient office visit costs around \$88 in a doctor’s office, or 109 percent of the Medicare rate. In a hospital outpatient department, the same visit would cost \$436, or 540 percent of the Medicare rate. Similarly, a doctor’s office charges \$23 to administer a flu shot, compared to \$183 in the hospital outpatient department, a 700 percent upcharge.¹⁹

Capping prices at 150 percent of the Medicare rate for a select set of services, regardless of the site of care, would yield significant savings. Brown University estimates the Fair Pricing Act would generate \$1.14 billion in annual savings. Patients with commercial insurance would save an estimated \$213 million through lower deductibles, coinsurance, and copayments.²⁰ Decreased health care spending and the existing insurance regulatory infrastructure for fully insured health plans would require insurers to seek rate reductions or issue rebates, leading to further premium savings for policyholders.²¹ See Figure 1. Site neutral payments for low-complexity services would also benefit uninsured patients through lower out-of-pocket spending. See Figure 2.



The Existing Insurance Regulatory Infrastructure Ensures that Health Care Savings from the Fair Pricing Act Would be Passed on to Payers and Patients

Two mechanisms in New York State’s insurance regulatory infrastructure would ensure that Fair Pricing Act savings are passed on to patients and employers. First, decreased health care spending for routine services would result in insurance premium adjustments under the state’s rate review process, also called “prior approval.” Second, statutory Medical Loss Ratio (MLR) requirements would require carriers to either lower premiums or issue rebates to enrollees when premiums are disproportionate to claims spending.²²

New York’s Insurance Rate Review Law Ensures that Premiums Are Adjusted in Response to Market Reforms

New York State law ensures that annual changes to health insurance premiums for individual and small group policies are subject to regulatory review through the New York State Department of Financial Services’ (DFS) prior approval process.²³ Each summer, state-regulated individual and small group market carriers file their proposed rates for the following calendar year with DFS, which publishes their applications on its website for

public comment. The carriers are also required to send notices of their proposed rates for the following year to individual enrollees and payers, directing them to DFS to file comments on the proposed rates. Thousands of comments are filed annually through this process. DFS reviews the rates and makes adjustments consistent with the criteria set forth in state law.

If New York were to implement the Fair Pricing Act, the prior approval process would require that actuaries consider this legislative change and associated price reductions when developing premium rates for the following year. Annually, DFS publishes instructions to the carriers detailing how their actuaries should account for the impact of market-wide changes, such as new legislation, when preparing their rate requests for the following plan year.

For example, in 2025, DFS issued instructions to the carriers directing them to include a line item to specify the “Impact of NYS Mental Health Initiatives.”²⁴ Additionally, the application annually includes a line item for the “Impact of other NYS Legislative changes.”²⁵ The health insurer rate requests must include an actuarial certification stating that the proposed rates are reasonable and fair.²⁶ DFS reviews these applications, provides comments, and may reject or modify proposed rates they determine to be “unreasonable, excessive, inadequate, or unfairly discriminatory.”²⁷

DFS often modifies and adjusts the carriers’ rates, sometimes substantially. For instance, in 2018, Empire Healthchoice Assurance requested a 24 percent rate increase for plan year 2019, citing morbidity increases due to healthier policyholders cancelling or choosing not to renew their coverage. DFS found that Empire themselves caused this issue by making significant changes to their product portfolio in the previous year. In disapproving the increase, DFS stated, “We do not believe it would be appropriate for Empire Healthchoice Assurance to pass the associated costs on to its policyholders.”²⁸

Should the Fair Pricing Act be enacted, the prior approval process would require that the resultant savings are passed onto enrollees and payers. Carriers are mindful of this requirement and have *sua sponte* incorporated reductions into their rate proposals, citing factors such as policy or service changes and corresponding changes in prices. For example:

- **HealthNow NY Inc.** requested a 3.2 percent rate reduction in their rate filing for plan year 2019, anticipating net savings due to factors such as the removal of the health insurance tax, a “disciplined contract renegotiation” with their pharmacy benefits manager, and “innovative reimbursement strategies.” DFS approved this reduction.²⁹
- **Independent Health Benefits Corporation** requested a 3.7 percent rate reduction for plan year 2021, similarly citing the permanent repeal of the health insurance tax, as well as lower claim trends. DFS determined that this rate adjustment was insufficient and approved a 5.3 percent reduction instead.³⁰
- **MetroPlus Health Plan, Inc.** requested a 3.9 percent rate reduction for plan year 2022 to reflect predicted improvements in the overall risk pool that would offset expected increases in claims spending. DFS approved this reduction.³¹

As prior rate filings show, New York’s annual prior approval process has a demonstrated track record ensuring that savings from legislative measures, such as the Fair Pricing Act, are passed through to health insurance enrollees and payers.

Federal and State Medical Loss Ratio Requirements Cap Insurance Company Profits

State and federal laws limit insurers' administration costs and profits through caps, known as medical loss ratios (MLRs). Under the Affordable Care Act, insurers are limited in the proportion of premium income that they are allowed to keep for administration, marketing, and profits. Federal MLR requirements dictate that insurers must spend at least 80 percent (in individual and small group markets) or 85 percent (in large group markets) of each premium dollar on health care expenses and quality improvement activities; the remainder can be used for administration and profits.³² When a carrier fails to meet the MLR requirements, over a three year average, it must issue rebates to enrollees and payers in the following plan year. Rebates are issued to those who held a policy at any point during the relevant calendar year, even if their coverage has since lapsed or otherwise ended.³³

New York State law takes this requirement even further, mandating a minimum MLR of 82 percent for individual and small group policies.³⁴ Insurers are instructed to consider historic and projected MLRs when proposing annual changes to premiums (discussed earlier), which are then reviewed by DFS to ensure rates are fair and abide by state law.³⁵

Critics of the MLR requirement note that it may lead to a “perverse motivation” to tolerate higher claim costs and discourage insurers from constraining premium increases. As claims increase, insurers can increase premiums and profits while still complying with the MLR requirement.³⁶ Said otherwise, if insurers keep only one slice (18 percent) of the premium pie, they are incentivized to inflate the size of the pie. See Figure 3.

The Fair Pricing Act would lower hospital prices for facilities that charge more than 150 percent of the Medicare rate for the list of MedPAC procedures. Accordingly, it would reduce the premium pie, and hence, overall amount of health care spending. Constraining hospital prices through the passage of the Fair Pricing Act would require insurers to adjust premiums to maintain the minimum required MLR, or else issue rebates.

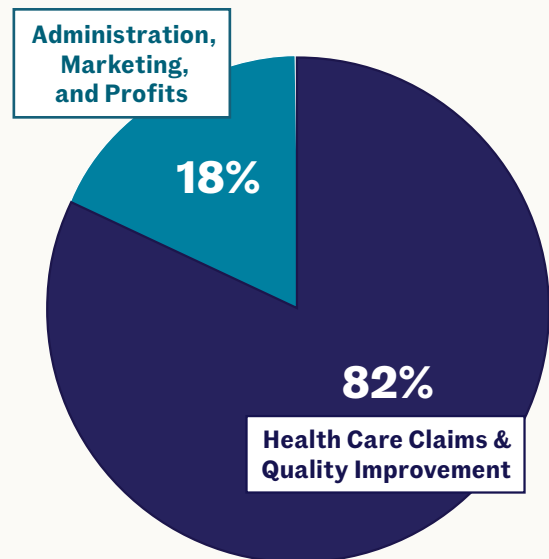


Figure 1. The Fair Pricing Act and Medical Loss Ratio Requirements

New York State medical loss ratio (MLR) requirements dictate that, in individual and small group markets, insurers must spend at least 82 percent of premium income on health care expenses and quality improvement activities. Insurers can retain a maximum of 18 percent of premium income for administration, marketing, and profits. This means that savings achieved through the Fair Pricing Act would necessarily be passed on to enrollees.

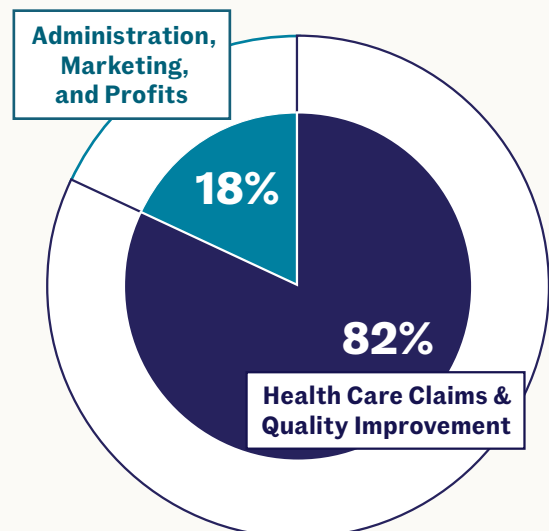
Status Quo

If insurers can only keep one slice (18 percent) of the premium pie, they are motivated to make the pie as big as possible. Instead of negotiating lower hospital prices to keep enrollee costs down, insurers are incentivized to keep prices high. The more dollars they spend on health care claims, the more dollars they can keep as profit while maintaining the minimum required 82:18 ratio.



After Enacting the Fair Pricing Act

The Fair Pricing Act (S705A/A2140) would cap prices for a specific set of outpatient services at 150 percent of the Medicare rate, regardless of the site of care. Constraining hospital prices would shrink the overall size of the premium pie, requiring insurers to adjust premiums to maintain the minimum required MLR (or else issue rebates).





Conclusion: State Site Neutral Policies Can Mitigate Federal Health Care Cuts

Enacting the Fair Pricing Act's (S705A (Krueger) |A2140 (Jackson)) site neutral policy in New York would provide a significant source of savings in the wake of federal cuts to health programs. New York has estimated that H.R. 1 will engender \$7.5 billion in health care system cuts that will leave an estimated 1.5 million New Yorkers uninsured.³⁷ Brown University researchers estimate that the Fair Pricing Act would generate \$1.1 billion in annual savings in commercial payments for insured New Yorkers alone, of which \$213 million will make health care more affordable for individual patients. Estimates of state savings through the Essential Plan and Medicaid programs are currently unavailable.

The Fair Pricing Act is a relatively limited reform that can improve health care affordability by curbing high health care prices for a limited set of routine outpatient

services, benefiting patients, unions, and employers. It would lead to out-of-pocket savings for patients with and without health insurance. In addition, the Fair Pricing Act would also lead to insurer savings on claim costs which would be passed on to employers, unions, and government payers. State and federal regulatory measures, such as the prior approval process and Medical Loss Ratio requirements, ensure that lower prices would lead insurers to reduce premiums and/or issue rebates, thereby passing on even more savings to enrollees and employers.

The Fair Pricing Act is a modest state-based health care payment reform that would generate significant savings for patients and payors. By enacting the Fair Pricing Act, New York policymakers can begin to address New York's second-in-the-nation status as the most expensive place to access health care.

Figure 2. Insured Patient Savings from the Fair Pricing Act

New York patients would benefit from the Fair Pricing Act (S705A/A2140). Here's how it works!

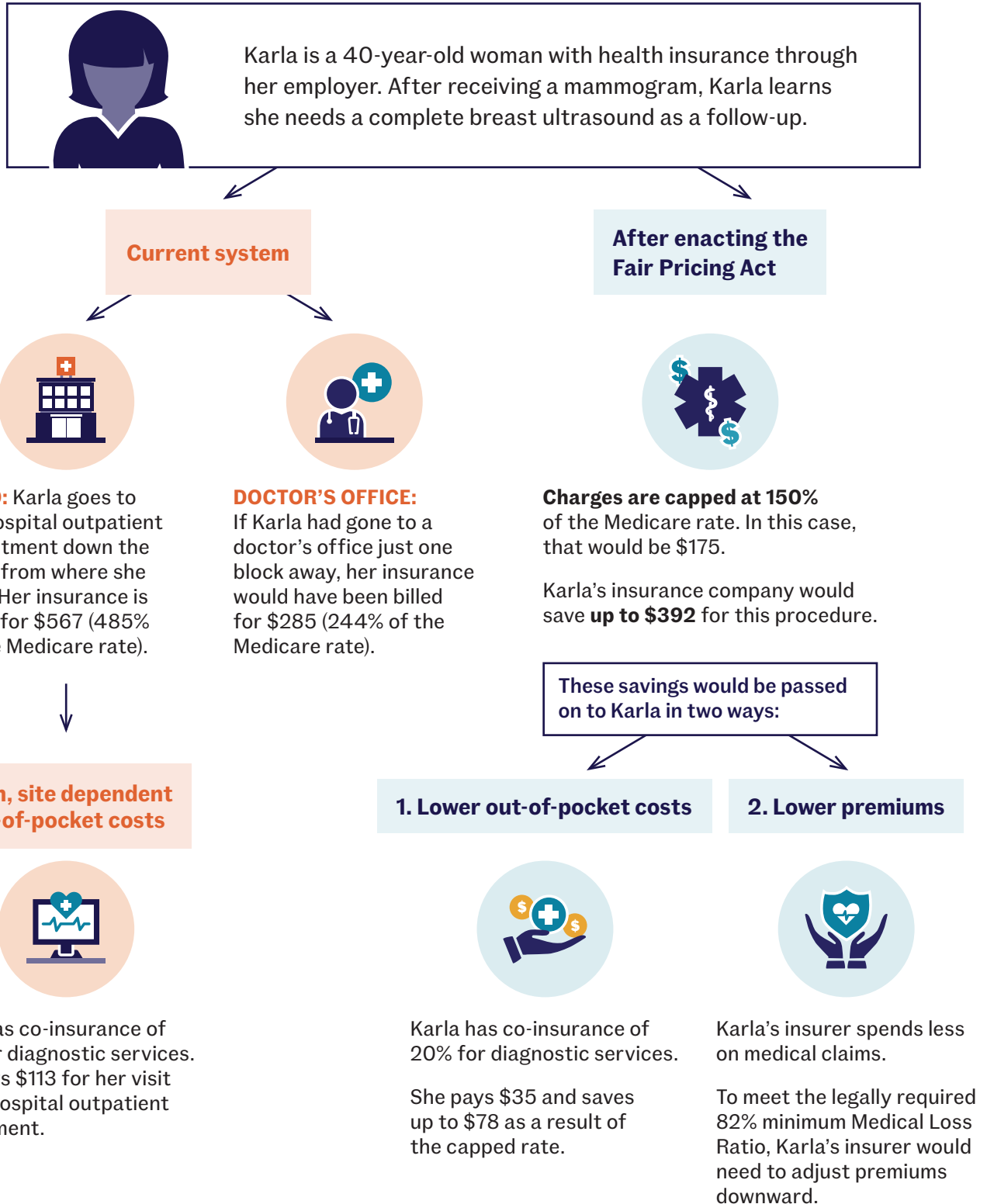
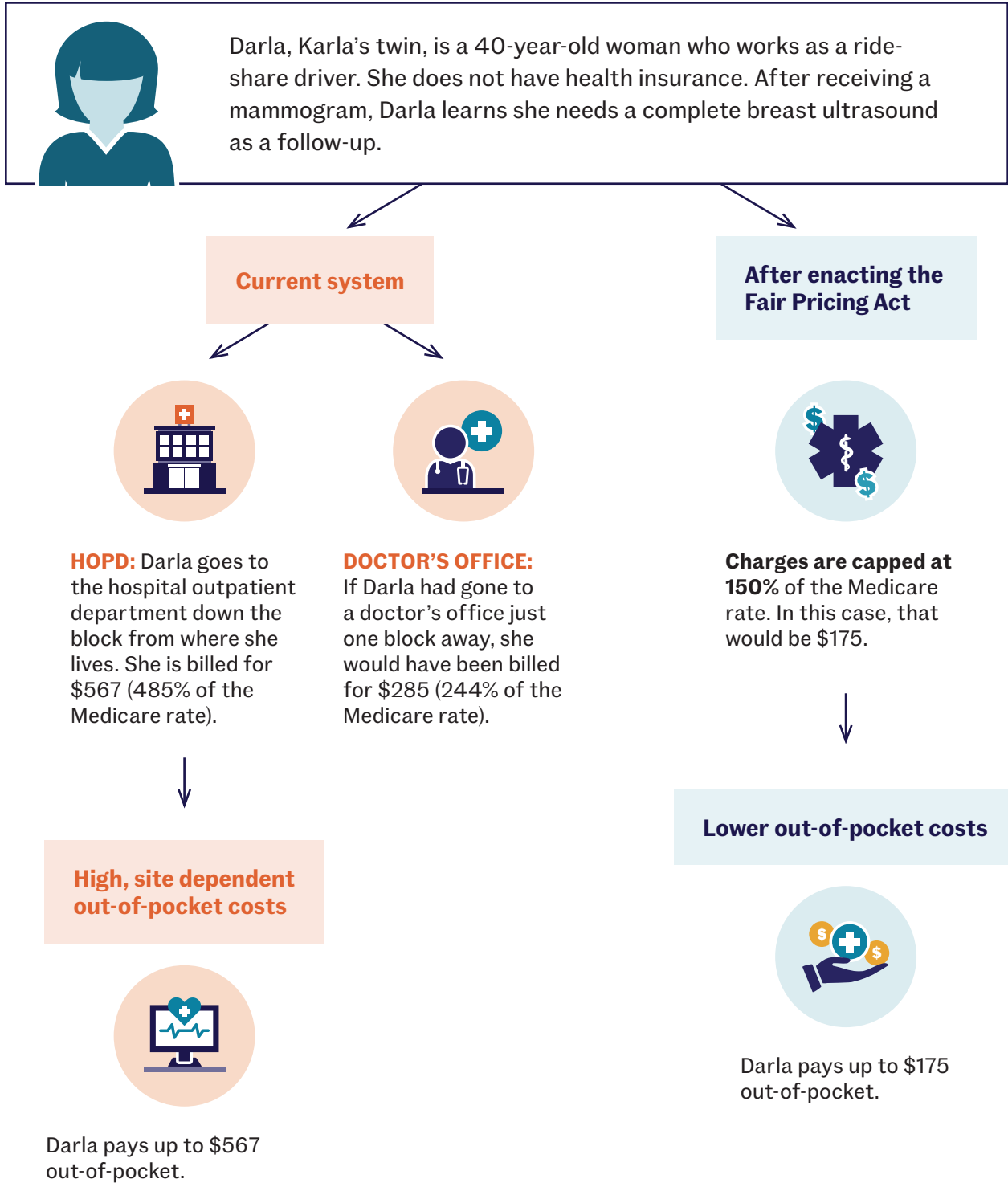


Figure 3. Uninsured Patient Savings from the Fair Pricing Act



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