Estimating Savings from the Fair Pricing Act and Commercial Site-Neutral Payments in New York State

AUTHORS:

Roslyn Murray, PhD, MPP, Haroon Janjua, MS, and Christopher Whaley, PhD

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Executive Summary

Background

Medicare and commercial insurance plans have long paid higher rates for services performed in hospital outpatient departments than those delivered in non-hospital settings, such as doctors' offices or ambulatory surgery centers (ASCs). For example, the price of a new patient office visit is $88 in a doctor's office, compared to $436 for the same service in a hospital setting. This payment disparity has fueled rising health care spending and contributed to the growing trend of hospital acquisition of physician practices, a phenomenon known as vertical integration. Research indicates that vertical integration can lead to higher prices and changes in patient care patterns, such as fewer referrals to more cost-effective non-hospital settings like ASCs. Given that many low-complexity procedures can be safely performed in non-hospital settings, there is increasing interest in implementing site-neutral payment policies to reduce health care spending without sacrificing care quality.

A notable proposal by the Medicare Payment Advisory Commission (MedPAC) advocates for site-neutral payments for low-complexity services, with the goal of reducing cost disparities between hospitals and non-hospital providers. In New York State, there has been a similar effort to introduce site-neutral payments for the commercial market through the Fair Pricing Act (S705/A2140), which would apply to the same low-complexity services recommended by MedPAC. This report examines the potential impact of such policies in New York's commercial health care market, estimating the savings that could result from capping payments at a percentage of Medicare's non-hospital rates.

Study Objective

This report evaluates the potential impact of the Fair Pricing Act and site-neutral payment on commercial health care spending in New York. We analyze price differences between hospital outpatient departments and non-hospital settings for a range of low-complexity services and estimate the potential savings that could be realized if commercial insurance payments were capped at a percentage of the Medicare non-hospital rates for these services.

Key Findings

Higher Prices in Hospital Settings: In 2022, commercial prices for services performed in hospitals were significantly higher than those in non-hospital settings. For example, the average price for performing certain low-complexity services was 4.2 times higher in a hospital than in a doctor's office: $452 per procedure in the hospital (371% of the Medicare non-hospital rate) compared to just $108 per procedure in the doctor's office (132% of the Medicare non-hospital rate).

Regional Price Variability: We observed substantial regional variation in commercial prices relative to Medicare non-hospital rates across New York. In some areas, such as North County and Mohawk Valley, the price differences between hospitals and doctors' offices were particularly pronounced, with hospital outpatient departments charging several times more.

Potential Savings from the Fair Pricing Act: Applying a cap of 150% of the Medicare non-hospital rate to commercial payments for these services would have saved New Yorkers approximately $1.14 billion in 2022, with consumer savings ranging from $168.9 million to $213.4 million in lower out-of-pocket expenses. Even with higher caps (e.g., 200% to 400% of Medicare), significant savings would still be realized, suggesting that site-neutral policies could effectively reduce health care spending.

State Budgetary Benefits: The Fair Pricing Act would also benefit state and city budgets by reducing spending on health care for government employees, retirees, and their dependents. For example, the New York City Health Benefits Program and New York State Health Insurance Program could have saved $120.9 million and $71.9 million, respectively, in 2022 under a 150% cap.

Conclusion

The findings of this report provide evidence that the Fair Pricing Act could reduce health care spending in New York's commercial insurance market. By capping payments for low-complexity services at a percentage of Medicare's non-hospital rates, New York could generate substantial savings—both for insurers and consumers. Site-neutral payment reforms also offer potential relief for state budgets, further emphasizing their value as a tool for addressing rising health care spending. As such, site-neutral payment policies offer a promising path forward in the pursuit of more equitable and sustainable health care pricing.

I. Introduction

By statute, Medicare pays more for services performed in hospital outpatient departments (HOPDs) than when the same service is performed in non-hospital facilities (i.e., doctors' offices or ambulatory surgery centers [ASCs]). For example, an epidural injection into the lumbar or sacral region costs $740.88 in the hospital outpatient setting, compared to just $255.89 in the doctor's office.[1] Most commercial insurers also pay more for services provided in hospitals than in non-hospital settings, with generally larger payment differences than those observed in Medicare.[2]

These "site-of-care" payment differentials contribute to increased health care spending and drive hospital acquisitions of physician practices (i.e., vertical integration). The number of physicians employed by hospitals or health systems has risen nearly 30% from 2019 to 2023, with over 55% of US physicians now employed by these organizations.[3] Research indicates that vertical integration contributes to both price increases and changes in referrals to hospitals. For instance, studies show that, in addition to collecting facility fees—an additional payment for the use of hospital facilities and equipment—professional fees for outpatient services also increase following integration.[4, 5, 6, 7] Further, one recent study found that hospital-employed physicians were 65% less likely to refer patients to ASCs—which are more cost-effective due to their streamlined operations—compared to those not involved in vertical integration.[8]

Given that many non-hospital settings like doctors' offices or ASCs provide equivalent or higher quality care at lower costs, site-neutral payment policies have emerged as a potential solution in the Medicare sector to address these payment differentials, curb vertical integration, and contain costs without diminishing care quality.[9] A prominent proposal comes from the Medicare Payment Advisory Commission (MedPAC), which advises policymakers on Medicare payment

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[1] Medicare Payment Advisory Commission. Chapter 8: Post-acute care. In: Report to Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission; June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf. Accessed Nov 4, 2024.
[2] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans. Santa Monica, CA: RAND Corporation; May 13, 2024. Available at: https://www.rand.org/pubs/research_reports/RRA1144-2.html. Accessed Nov 4, 2024.
[3] Physicians Advocacy Institute. PAI-Avalere Report on Physician Employment Trends and Acquisitions of Medical Practices: 2019-2023. Available at:https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023. Accessed Jan 30, 2025.
[4] Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of financial integration between physicians and hospitals with commercial health care prices. JAMA Intern Med. 2015;175(12):1932-9.
[5] Baker LC, Bundorf MK, Kessler DP. Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending. Health Aff. 2014;33(5):756-63.
[6] Goodwin J, Arnold DR, Fulton BD, Scheffler RM. The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence. INQUIRY. 2021;58.
[7] Capps C, Dranove D, Ody C. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending. J Health Econ. 2018;59:139-52.
[8] Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: evidence from outpatient procedure markets. J Health Econ. 2022;81:102569. doi:10.1016/j.jhealeco.2021.102569.
[9] Robinson JC, Whaley CM, Dhruva SS. Prices and complications in hospital-based and freestanding surgery centers. Am J Manag Care. 2024;30(4):179-184. doi:10.37765/ajmc.2024.89529. PMID: 38603532.

policy. MedPAC advocates for site-neutral payments for a select group of low-complexity, low-intensity medical services that are provided more than half the time in lower-cost settings. These services include procedures such as X-rays, minor procedures (e.g., skin tag removal), and drug injections. MedPAC estimates that implementing these recommendations could save patients and taxpayers billions of dollars.[10]

Defining Key Terms

Hospital Outpatient Departments (HOPDs): Departments within a hospital that provide outpatient services, meaning services that do not require an overnight stay. They offer a variety of medical services, such as diagnostic tests, minor surgeries, preventive care, and treatments that are less intensive than those in inpatient settings.

Ambulatory Surgery Centers (ASCs): Health care facilities that specialize in providing same-day surgical care, including diagnostic and preventive procedures. Patients receive procedures that typically do not require an overnight stay. They are distinct from hospitals, operating as standalone facilities.

Facility Fees: Generally understood as a payment that covers the operational costs of the hospital facility, including overhead, equipment, and administrative support. It is typically higher than fees for similar services in non-hospital settings, like doctors' offices, because hospitals incur additional costs to maintain their facilities and infrastructure.

Commercial health care spending in New York is high and rapidly rising, primarily driven by higher prices for hospital services.[11] In 2020, New York's total commercial health care spending reached $75 billion. Hospital care accounted for 39.3% of total personal health care expenditures in the state, which was higher than US spending on hospital care (37.8%) in 2020.[12] Additionally, spending on outpatient services accounted for nearly a quarter of total commercial per capita health care spending in New York in 2017.[13] In response, a push for legislative reform is underway, led by the 32BJ Labor Industry Cooperation Trust Fund. The proposed Fair Pricing Act (S705/A2140) seeks to establish site-neutral payments in the

[10] Medicare Payment Advisory Commission. Chapter 8: Post-acute care. In: Report to Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission; June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf. Accessed Nov 4, 2024.

[11] NYHealth and Health Care Cost Institute. Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York. NYHealth Foundation. 2019 July 30 [cited 2025 Feb 3]. Available from: https://nyhealthfoundation.org/wp-content/uploads/2020/02/Health-Care-Spending-in-NY-2019.pdf

[12] Centers for Medicare & Medicaid Services. NHE Fact Sheet. CMS. 2024 Dec 18 [cited 2025 Feb 3]. Available from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet

[13] NYHealth and Health Care Cost Institute. Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York. NYHealth Foundation. 2019 July 30 [cited 2025 Feb 3]. Available from: https://nyhealthfoundation.org/wp-content/uploads/2020/02/Health-Care-Spending-in-NY-2019.pdf

commercial market, limiting prices for certain services to 150% of Medicare's non-hospital rates.[14, 15] These services, identified by MedPAC as safe to perform in non-hospital settings, could generate substantial savings. Our analysis estimates that the Fair Pricing Act would have saved New Yorkers $1.14 billion in 2022.

II. Background

A. Medicare payment differences for services in doctors' offices vs. hospital outpatient departments

Medicare covers physician services provided in doctors' offices under the Medicare Physician Fee Schedule (MPFS), which sets payment rates based on the expected costs for labor, materials, and the services provided by physicians and other health care professionals. In contrast, services delivered in hospital outpatient departments incur both a professional fee (under the MPFS) and an additional facility fee. The facility fee is determined by the outpatient prospective payment system (OPPS) and reflects the costs associated with the facility, such as medical supplies and equipment. As a result, Medicare generally pays more for the same service when it's provided in a hospital, due to the added facility fee. For more complex procedures, it makes sense that the facility fee is higher in the hospital, especially when doctors' offices lack the necessary facilities and equipment. However, providers are increasingly offering low-complexity, low-intensity services

Actual 2022 payment rates: Chest X-ray with 2 views	
Medicare non-hospital rate	
Medicare MPFS rate	$37.50
Service in doctor's office	
Commercial professional fee	$65.59
Service in hospital outpatient department	
Commercial professional fee	$18.05
Commercial facility fee	$223.21
Total payment	$241.35
Commercial price as a percentage of the Medicare non-hospital rate	
Doctor's office	175%
Hospital outpatient department	644%

Notes: *MPFS = Medicare physician fee schedule. The payment rates in this table are those for Current Procedural Terminology code 71046, which was the most common procedure in 2022.*

[14] Relates to fair pricing for low-complexity, routine medical care. S705, New York State Senate, 2025. https://www.nysenate.gov/legislation/bills/2025/S705
[15] Relates to fair pricing for low-complexity, routine medical care. A2140, New York State Assembly, 2025. https://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A2140&term=2025&Text=Y

in the hospital outpatient department—which are reimbursed at higher rates under the OPPS—even though these services could safely be performed in a doctor's office. Certain services are not reimbursed under the OPPS in Medicare, meaning they do not incur a facility fee. Examples include ambulance services, clinical diagnostic laboratory services, and screening/diagnostic mammography.[16] However, these same services may incur a facility fee under commercial insurance plans, as commercial payers often have different payment structures and contracts. While these services are not addressed in this report, they represent an important consideration for broader site-neutral payment discussions.

B. Site-neutral payment efforts in Medicare

Efforts within Medicare to adopt site-neutral payment policies have been underway in recent years. In March 2012, MedPAC recommended that Medicare should pay the same amount for both new and established patient office visits—called evaluation and management (E&M) services—whether they happen in a hospital outpatient department or a doctor's office. Since then, through the 2015 Bipartisan Budget Act, Medicare has adopted site-neutral payments for E&M office visits, but only at off-campus hospital outpatient departments, which are hospital-owned facilities that operate similarly to independent doctors' offices, with several exemptions. Thus, these services are still reimbursed at higher rates for Medicare patients receiving care at on-campus hospital outpatient departments, as well as in the commercial market.

Actual 2022 payment rates: Complete Breast Ultrasound	
Medicare non-hospital rate	
Medicare MPFS rate	$117.08
Service in doctor's office	
Commercial professional fee	$285.99
Service in hospital outpatient department	
Commercial professional fee	$100.03
Commercial facility fee	$460.12
Total payment	$567.3
Commercial price as a percentage of the Medicare non-hospital rate	
Doctor's office	244%
Hospital outpatient department	485%

***Notes**: MPFS = Medicare physician fee schedule. The payment rates in this table are those for Current Procedural Terminology code 76641, which is the third most common procedure in 2022.*

[16] OPPS Payment Status Indicators. Noridian Healthcare Solutions. 2023 Dec 9 [cited 2025 30 Jan]. Available from: https://med.noridianmedicare.com/web/jea/provider-types/opps/opps-payment-status-indicators

In June 2023, MedPAC identified additional low-complexity, low-intensity services for which there is no justification for a significant price difference between hospital outpatient departments and doctors' offices.[17] By analyzing groups of services within the OPPS known as ambulatory payment classifications, MedPAC identified procedures that could safely be performed in doctors' offices, as these services were already conducted in the office setting more than half the time. Examples include services like initial physical exams, removal of skin tags, and nasal endoscopies. MedPAC concluded that it would be reasonable to pay the same rate for these services, regardless of whether the service is performed in a hospital outpatient department or a doctor's office. MedPAC also identified procedures that are too complex for doctors' offices but can be safely performed in an ASC. Examples include treatments for shoulder dislocations, rib fractures, and hip joint biopsies. MedPAC recommended that these services be reimbursed at the Medicare ASC payment rate, which is lower than the rate paid for the same services when performed in a hospital outpatient department.

Actual 2022 payment rates: New Patient Office Visit	
Medicare non-hospital rate	
Medicare MPFS rate	$80.80
Service in doctor's office	
Commercial professional fee	$88.39
Service in hospital outpatient department	
Commercial professional fee	$73.84
Commercial facility fee	$362.27
Total payment	$436.11
Commercial price as a percentage of the Medicare non-hospital rate	
Doctor's office	109%
Hospital outpatient department	540%

***Notes**: MPFS = Medicare physician fee schedule. The payment rates in this table are those for Current Procedural Terminology code 99202, which is a common evaluation & management procedure.*

Although E&M office visits and procedures identified by MedPAC continue to receive higher reimbursement rates in on-campus hospital outpatient departments from both Medicare and commercial payers, state and federal policymakers are increasingly considering site-neutral payment policies for these services.

[17] Medicare Payment Advisory Commission. Chapter 8: Post-acute care. In: Report to Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission; June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf. Accessed Nov 4, 2024.

III. Data & Methodology

A. Study Data

Our primary analysis is based on 2022 commercial claims data from the Health Care Cost Institute (HCCI), which aggregates data from major health insurers in the US, including Aetna, Humana, Kaiser Permanente, and Blue Cross and Blue Shield plans. This dataset represents approximately 30% of the commercially insured population in New York State and includes 17.2 million outpatient and professional claims for 2,561 procedures identified by MedPAC as suitable for safe delivery in non-hospital settings (Appendix Exhibit A1).[18] Additionally, we incorporated data from the MPFS and the Medicare ASC payment system to calculate Medicare-equivalent payments for each procedure.

We excluded claims for which we could not calculate the Medicare-equivalent payment (n = 552,330). To reduce the influence of pricing outliers and potential billing errors, we also trimmed the top and bottom 1% of commercial prices (i.e., "allowed amounts"). To ensure a precise comparison of prices between hospital and non-hospital settings, we focused on specific service locations. Of the 2,561 procedures included in our analysis, 2,062 were identified by MedPAC as safe for performance in doctors' offices, given that they were already performed there more than 50% of the time. This group also includes the 9 E&M services (CPT codes 99202–99205, 99211–99215) Medicare pays site-neutrally in off-campus hospital outpatient departments. For these procedures, we analyzed claims from both hospital outpatient departments (place of service [POS] code = 22) and doctors' offices (POS code = 11). For the remaining 499 procedures—those that MedPAC deemed appropriate for ASCs—we restricted our analysis to claims from both HOPDs and ASCs (POS code = 24). Services delivered in emergency or inpatient settings were excluded from the analysis, as our focus was on these specific places of service.

We implemented additional steps to further minimize capturing potential coding or billing errors. Under the Medicare outpatient prospective payment system and ASC payment system, Medicare pays separately for professional services—those provided by a physician. For services performed in both the hospital and ASC settings, there should be a corresponding professional

[18] Medicare Payment Advisory Commission. Chapter 8: Post-acute care. In: Report to Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission; June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf. Accessed Nov 4, 2024.

fee along with the facility fee in the claims data.[19, 20] If we could not find a matching professional claim alongside a facility claim for a specific date-patient-procedure combination, we excluded that claim from our analysis. Furthermore, to ensure comparability between the hospital and non-hospital setting, we included only those procedures that had claims present in both locations. For instance, if a procedure was performed in the office setting but not in the hospital in 2022, we excluded it from our analysis. Our final sample included 12,781,547 total professional and outpatient claims (Appendix Exhibit A2).

B. Study Methodology

The analysis was carried out in multiple phases. First, we compared commercial prices for the relevant services in the hospital to commercial prices for these same services in the non-hospital setting. We also compared commercial prices for these services to the Medicare non-hospital rate by setting. Specifically, for services deemed appropriate for doctors' offices, we compared commercial prices to Medicare's payment rates for services delivered by physicians and other health care professionals in office settings using the Medicare physician fee schedule. For services identified as suitable for ASCs, we compared commercial prices to Medicare ASC payment rates (see Appendix Methods for details on our approach for calculating commercial and Medicare rates).

Second, we estimated the potential savings for New Yorkers if payments for the applicable services were capped at a percentage of the Medicare non-hospital rate, applied across all care settings (e.g., 150% of the MPFS rate for low-complexity services that can be safely provided in doctors' offices). We assumed that price changes would only occur for procedures with payments exceeding the cap, as the proposed policy would prevent any price increases above this threshold. Then, we summed the price reductions across service types and settings to estimate overall savings. Given that the HCCI data represent only about 30% of commercially insured enrollees in New York, we adjusted our estimates by dividing them by 0.30 to scale the savings to the broader commercial market in the state. We also performed the analysis with alternative caps set at 100, 200, 250, 300, 350, and 400% of Medicare.

[19] Medicare Payment Advisory Commission "Payment Basics: Outpatient Prospective Payment System." MedPAC, 2024 October [cited 2025 Jan 30]. Available from: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_OPD_FINAL_SEC.pdf
[20] Chernew ME. Disparities in payment across sites encourage consolidation. Health Serv Res. 2021 Feb;56(1):5-6. doi: 10.1111/1475-6773.13612. PMID: 33616930; PMCID: PMC7839635.

C. Limitations

Our study is subject to several limitations. First, HCCI includes commercial claims from a subset of commercial insurers in New York. Therefore, our study may lack representativeness because it assumes that these rates apply similarly to all commercial insurers across the state. Because larger, dominant insurers often negotiate better rates due to their market leverage, there is potential for both over- or underestimation of savings.[21, 22, 23] If the insurers included in the HCCI dataset generally secure higher or lower prices than other insurers in the state, our estimates may not reflect the broader commercial insurance market.

Second, we encountered some challenges in consistently identifying the setting for certain claims. While we used place of service and type of bill (TOB) codes to assign the site of care, there were instances where these codes did not align. To resolve this, we grouped claims for each patient on a given day, assuming they all occurred at the same site of service. We identified the site of service based on the most frequent (i.e., modal) POS or TOB code for that set of claims. Third, when calculating the Medicare ASC facility fee, we were unable to apply the hospital-specific wage index to account for geographic variations due to limitations in linking hospital-specific data within the HCCI dataset. As an alternative, we used an average wage index by ZIP code to adjust the facility portion regionally.

Fourth, although we limited our analysis to claims with both a facility and professional fee for services received in the hospital or ASC, there may be cases where insurers bundle these fees into a single payment, bill them on separate days, or already do not pay the facility fee for certain services. Because we cannot determine whether this is due to contracting decisions or data errors, we excluded these services from our analysis, which likely leads to an underestimation of potential savings. Fifth, since we are unable to identify specific facilities in the HCCI data, this analysis does not take into account the facility exemptions outlined in the bill. Finally, our model does not account for potential adverse effects that could result from reductions in hospital revenue. For example, as services shift to ASCs and doctors' offices, these providers may gain more negotiation leverage, potentially driving up prices for other services.

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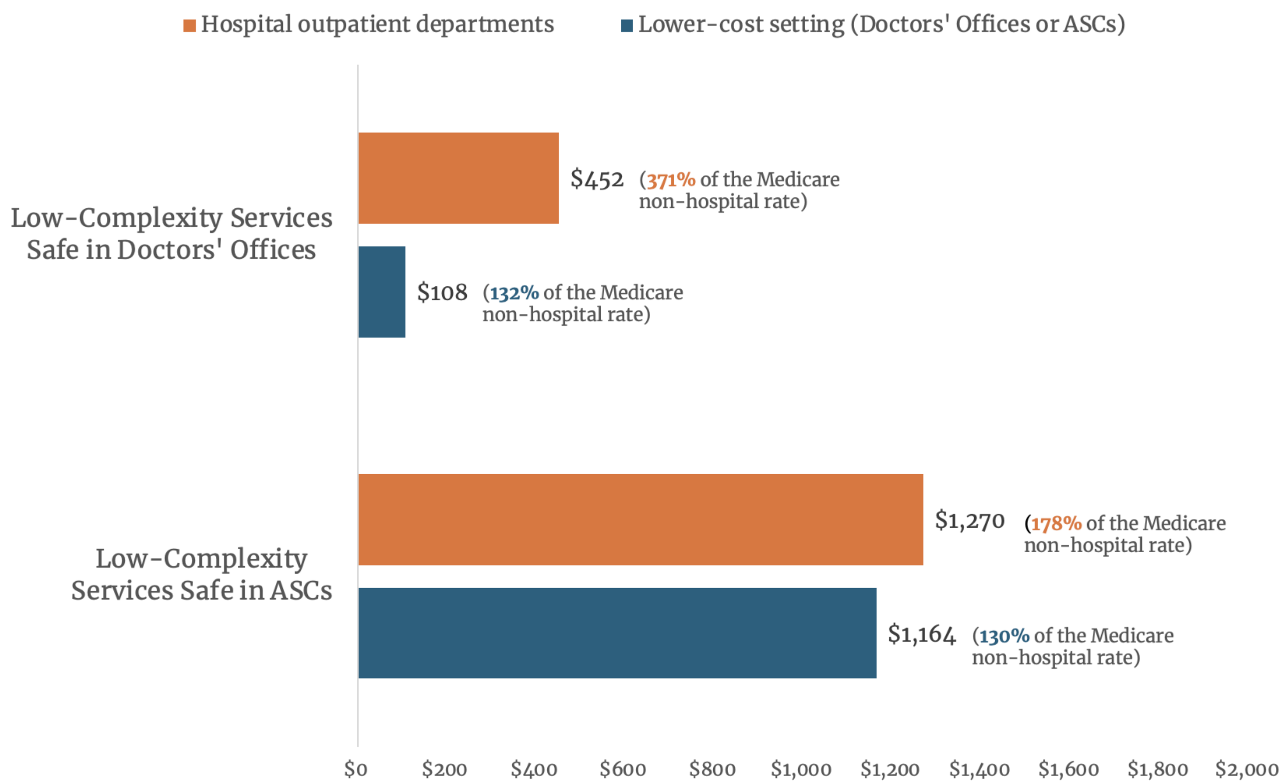
[21] Barrette E, Gowrisankaran G, Town R. Countervailing Market Power and Hospital Competition. NBER Working Paper No. 27005. National Bureau of Economic Research; 2020. Available at: https://www.nber.org/papers/w27005. Accessed Nov 5, 2025.
[22] Dafny L, Duggan M, Ramanarayanan S. Paying a premium on your premium? Consolidation in the US health insurance industry. American Economic Review. 2012; 102(2):1161–85.
[23] Scheffler RM, Arnold DR. Insurer market power lowers prices in numerous concentrated provider markets. Health Affairs. 2017; 36(9):1539–1546.

IV. Key Findings

A. Commercial prices are higher in hospital than non-hospital settings

We grouped the services recommended by MedPAC into two categories to compare commercial prices in the hospital versus the non-hospital setting. The two categories include: 1) low-complexity services safe in doctors' offices, which are the 2,062 low-complexity, low-intensity services that MedPAC identified would be safe to perform in doctors' offices; and 2) low-complexity services safe in ASC, which are the 499 low-complexity, low-intensity services that MedPAC identified would be safe to perform in ASCs.

Exhibit 1. Commercial prices in the hospital versus non-hospital setting by service category, 2022



Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *ASC = ambulatory surgery center. "Low-Complexity Services Safe in Doctors' Offices" are the low-complexity services identified by the Medicare Payment Advisory Commission (MedPAC) as safe to perform in office settings. "Low-Complexity Services Safe in ASCs" are the services identified by MedPAC as safe to perform in ASC settings.*

When examining commercial prices for these services provided in the hospital versus non-hospital setting, we found that the weighted average prices for each service type were higher in hospital settings in 2022. The average price per procedure for the low-complexity services that could safely be performed in the doctors' office was 4.2 times higher in the hospital, at $452, or 371% of the Medicare non-hospital rate, compared to just $108, or 132% of the Medicare non-hospital rate, in the doctor's office. For the procedures that could safely be performed in ASCs, the average price per procedure was only 1.1 times higher in the hospital, at $1,270, or 178% of the Medicare non-hospital rate, compared to $1,164, or 130% of the Medicare non-hospital rate, in the ASC (Exhibit 1). In addition to higher average prices, the price distribution in the hospital setting is wider compared to the non-hospital setting for each of these service types (Exhibit 2).

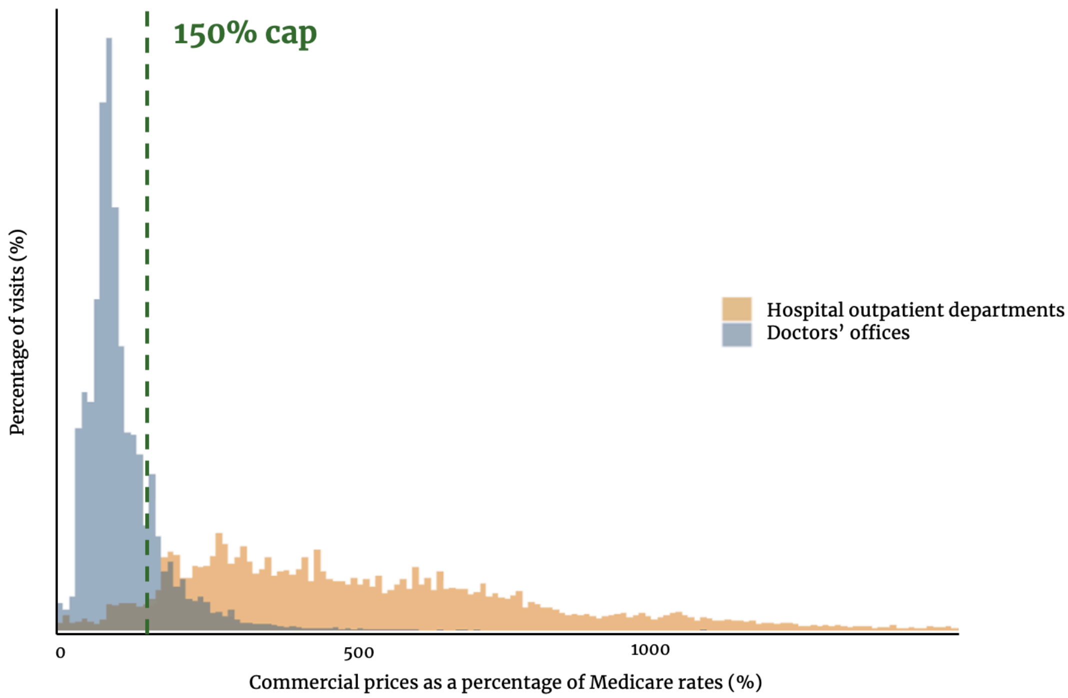
Exhibit 2. Distribution of commercial prices by service category and setting in New York, 2022

Service category	Setting	25th percentile	50th percentile	75th percentile	90th percentile	95th percentile
Low-complexity services safe in doctors' offices	Hospital	$238	$340	$543	$940	$1,241
	Non-hospital	$35	$80	$147	$255	$351
Low-complexity services safe in ASCs	Hospital	$983	$1,344	$1,628	$1,786	$1,869
	Non-hospital	$878	$993	$1,459	$1,813	$2,001

Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Note: *ASC = ambulatory surgery center.*

We also compared commercial prices to the Medicare non-hospital rate (i.e., prices as a percentage of the Medicare non-hospital rate or "relative prices") to show an objective benchmark for the rate the federal government considers to be sufficient for the same services. Exhibit 3 presents the distributions of commercial prices as a percentage of the Medicare non-hospital rate for the 2,062 services that could safely be performed in doctors' offices. We compare the distribution of relative prices in hospital outpatient departments to the distribution of relative prices in doctors' offices. The distribution of relative prices in the office setting is narrower, with a higher concentration of services at lower, more consistent relative price points around the mean. In contrast, prices for the same services provided in the hospital show greater variation, with a wider spread, and more outliers relative to the Medicare non-hospital rate (Appendix Exhibit A3).

Exhibit 3. Distribution of commercial prices relative to Medicare non-hospital rates for services delivered in hospital outpatient departments compared with doctors' offices, 2022

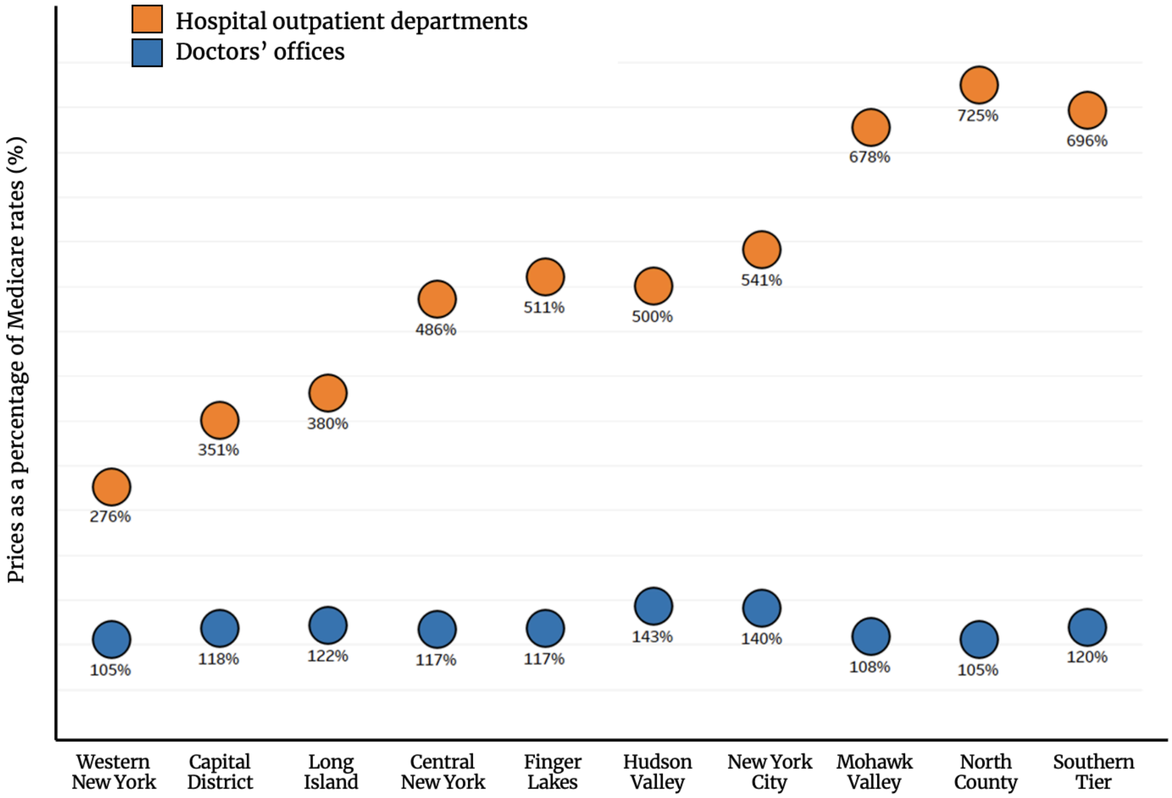


Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *This figure shows the distribution for evaluation and management and other low-complexity office-based services. The dotted green line represents the point at which the cap will be implemented under the Fair Pricing Act.*

B. Commercial prices relative to Medicare non-hospital rates are significantly higher in hospitals than doctors' offices across New York

Next, we examined commercial prices as a percentage of the Medicare non-hospital rate for the 2,062 services that can safely be delivered in doctors' offices across the ten regions in New York. The comparison was made between hospital outpatient departments and doctors' offices. In the doctor's office, commercial prices as a percentage of the Medicare non-hospital rate ranged from 105% in Western New York and North County to 143% in Hudson Valley. In contrast, relative prices in hospital outpatient departments were significantly higher, ranging from 276% of the Medicare non-hospital rate in Western New York to 725% in North County. The difference between relative prices in the two settings varied widely, with a 171 percentage point gap in Western New York and a 620 percentage point gap in North County (Exhibit 4, Appendix Exhibit A4). All regions showed significant differences between the relative prices in hospitals compared to the relative prices in doctors' offices for these low-complexity services, but the largest differences were in Mohawk Valley, North County, and the Southern Tier.

Exhibit 4. Comparison of commercial prices to Medicare non-hospital rates for low-complexity services in hospitals and doctors' offices by region in New York state, 2022

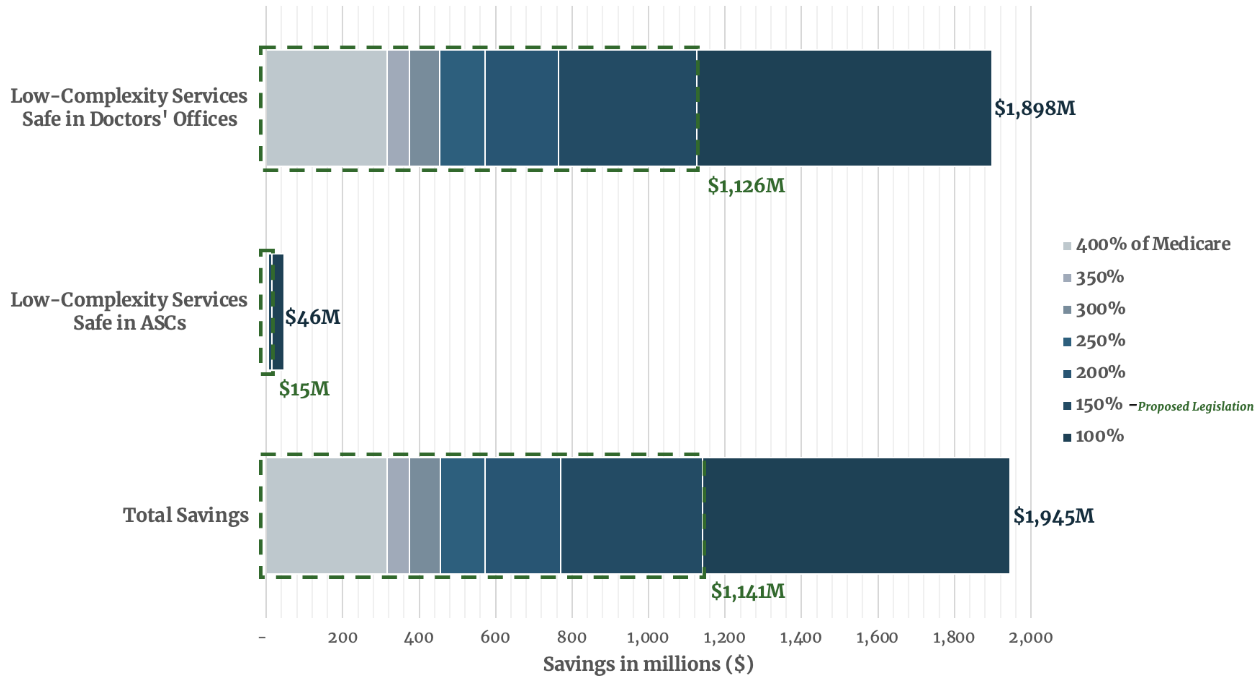


***Source**: Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
***Notes**: The figure presents average commercial prices paid in hospital outpatient departments and doctors' offices, relative to the Medicare physician fee schedule payment for low-complexity services identified by the Medicare Payment Advisory Commission as safe to perform in doctors' offices. Distributions are limited to procedures that are > 20% of Medicare and < 2,000% of Medicare.*

C. Commercial site-neutral payment policies could generate sizable savings for New Yorkers

We estimated savings from capping commercial prices at the Medicare non-hospital rate across all care settings. Under the Fair Pricing Act, with a cap set at 150% of the Medicare non-hospital rate, savings would have reached $1,140.9 million, or about 19.6% of total statewide revenue from these services. Even at higher caps, significant savings would still be realized: a 400% cap would save $316.5 million (5.5% of revenue), a 350% cap would save $375.4 million (6.5% of revenue), a 300% cap would save $454.6 million (7.8% of revenue), a 250% cap would save $573.1 million (9.9% of revenue), and a 200% cap would save $769.4 million (13.2% of revenue). A lower cap, set at 100% of the Medicare non-hospital rate, would generate $1,944.6 million in savings (33.5% of revenue). Most savings would come from low-complexity services that can be safely performed in doctors' offices (Exhibit 5 & 6, Appendix Exhibits A5).

Exhibit 5. Estimated savings for New Yorkers from capping low-complexity service prices at a percentage of Medicare non-hospital rates, 2022



Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *Graph shows annual savings by service type and overall for New Yorkers under a cap at 100, 150, 200, 250, 300, 350, and 400% of the Medicare non-hospital rate. Data labels are reported at the 150% cap (in green) and 100% cap (in dark blue) levels.*

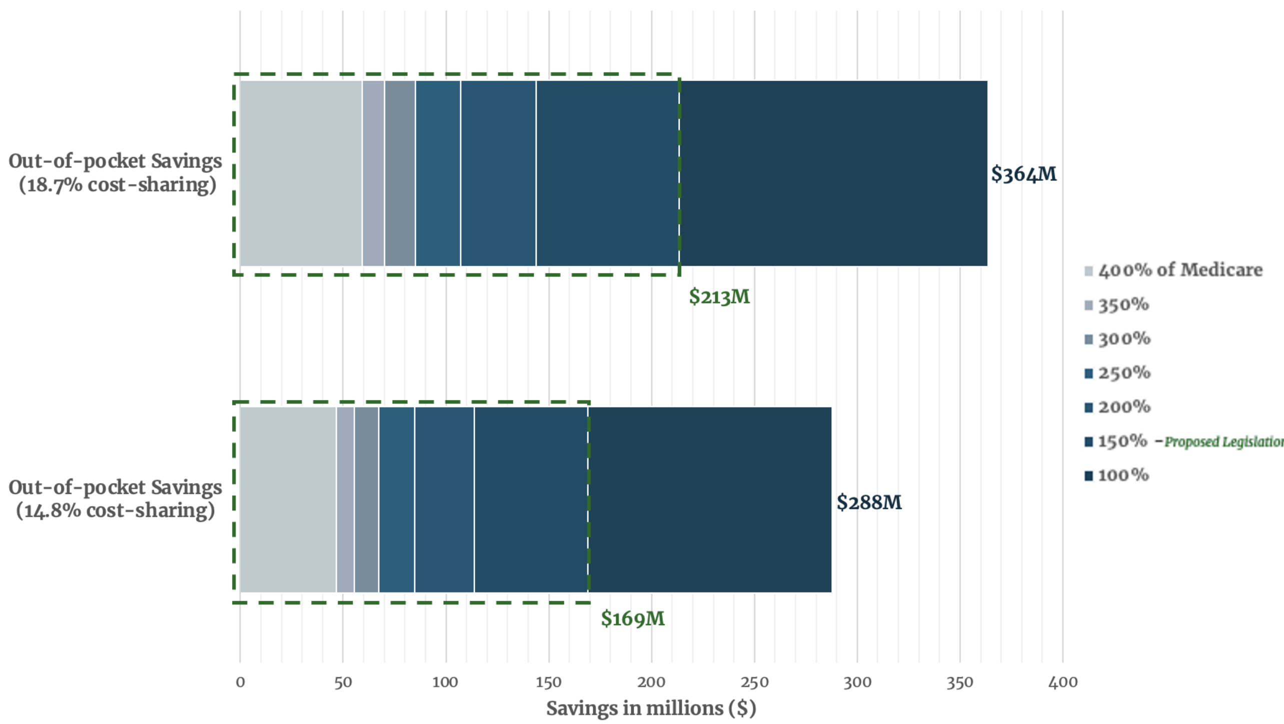
Exhibit 6. Estimated total and out-of-pocket savings in millions at different cap levels, 2022

Cap level (% of Medicare)	Total savings in millions, $	Range in out-of-pocket savings in millions, $
100% of Medicare	1,944.6	287.8 - 363.6
150% of Medicare	1,140.9	168.9 - 213.4
200% of Medicare	769.4	113.9 - 143.9
250% of Medicare	573.1	84.8 - 107.2
300% of Medicare	454.6	67.3 - 85.0
350% of Medicare	375.4	55.6 - 70.2
400% of Medicare	316.5	46.8 - 59.2

Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *We assume enrollees experience 14.8% of the savings (median, conservative estimate) and 18.7% of the savings (mean).*

We also estimated patient savings from reductions in out-of-pocket spending. While existing literature suggests that patient cost-sharing for inpatient and outpatient hospital services typically ranges from 4% to 16.4%,[24, 25, 26, 27] our analysis found that, on average, patients paid about 18.7% of the total price for the low-complexity services included in our study, with a median of 14.8% (Appendix Exhibit A6). Based on this, we estimated out-of-pocket savings for New Yorkers receiving these services in 2022 using both the median (the more conservative estimate) and the mean. Under the Fair Pricing Act, we estimate that New Yorkers would have saved between $168.9 million and $213.4 million in lower out-of-pocket costs. These savings would decrease with higher caps. At a 400% cap, out-of-pocket savings would range from $46.8 million to $59.2 million; at 350%, savings would range from $55.6 million to $70.2 million; at 300%, savings would range from $67.3 million to $85.0 million; at 250%, from $84.8 million to $107.2 million; and at 200%, from $113.9 million to $143.9 million. At a 100% cap, New Yorkers would experience the greatest savings in out-of-pocket spending, ranging from $287.8 million to $363.6 million (Exhibits 6 & 7).

Exhibit 7. Estimated out-of-pocket savings for New Yorkers from capping low-complexity service prices at a percentage of Medicare non-hospital rates, 2022



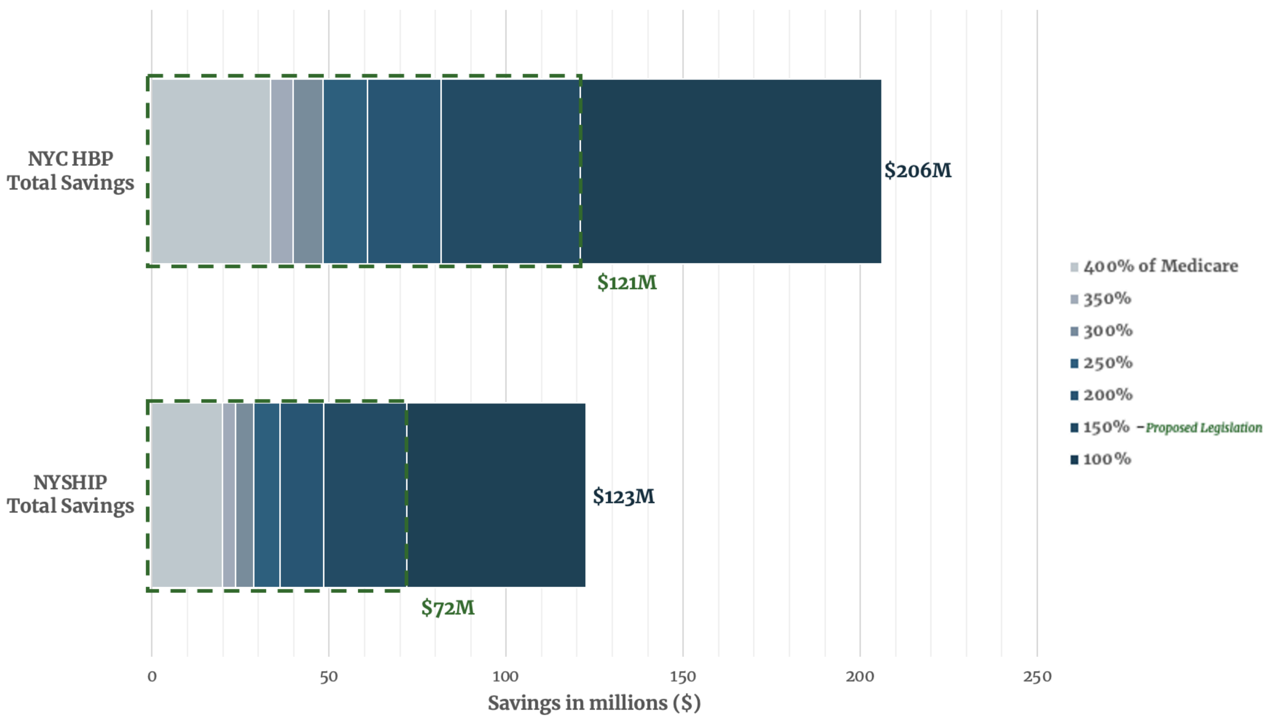
***Source**: Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
***Notes**: We assume enrollees experience 14.8% of the savings (median, conservative estimate) and 18.7% of the savings (mean). Data labels are reported at the 150% cap (in green) and 100% cap (in dark blue) levels.*

[24] Adrion ER, Ryan AM, Seltzer AC, Chen LM, Ayanian JZ, Nallamothu BK. Out-of-pocket spending for hospitalizations among nonelderly adults. JAMA internal medicine. 2016 Sep 1;176(9):1325-32.
[25] Liu JL, Levinson ZM, Qureshi NS, Whaley C. Impact of policy options for reducing hospital prices paid by private health plans. RAND; 2021 Feb 18.
[26] Spiegel J, Fronstin P. Recent trends in patient out-of-pocket cost sharing. Employee Benefit Research Institute; 2022 July 28.
[27] Kannan S, Stevens J, Song Z. Growth in patient cost sharing for hospitalizations with and without intensive care among commercially insured patients: Health Affairs. 2023 Sep 1;42(9):1221-9.

D. Commercial site-neutral payment could also alleviate state budgetary pressures

We estimate that savings from the Fair Pricing Act would help alleviate budgetary pressures by reducing health care spending for state and city employees, retirees, and their dependents. Of the $1.14 billion in estimated savings from the Fair Pricing Act, we project that the New York City Health Benefits Program would have saved $120.9 million and the New York State Health Insurance Program (NYSHIP) would have saved $71.9 million (Exhibit 8).[28, 29] NYSHIP's savings would have been about 0.03% of the state budget in 2022.[30]

Exhibit 8. Estimated savings for New York City Health Benefits Program and New York State Health Insurance Program, 2022



Source*: Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes*: We assumed that 6.3% of individuals with employer-sponsored insurance (ESI) in New York were covered by the New York State Health Insurance Program and 10.6% of individuals with ESI were covered by the New York City Health Benefits Program in 2022. These data are based on reported non-retiree members in the state and city plans in 2022 (572k and 958k, respectively). The total ESI lives in New York state are reported by Kaiser Family Foundation as 9,045,200 million in 2022.*

[28] Annual Report of Empire Plan Hospital Pricing - Plan Years 2022 & 2023. New York State | Department of Civil Service. 2024 [cited 2025, Feb 1]. Available from: https://www.cs.ny.gov/extdocs/pdf/2024%20Hospital%20Transparency%20Report.pdf
[29] Babette M. Health Insurance Program Quarterly Statistical Statement. 2023 June 2. Memorandum.
[30] New York | Urban Institute. [cited 2025, Feb 1]. Available from: https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/projects/state-fiscal-briefs/new-york

V. Discussion

Commercial prices for low-complexity, low-intensity services are significantly higher in hospitals compared to non-hospital settings, with prices in hospitals 4.2 times higher than in doctors' offices. For services that can be delivered in ASCs, the price difference is smaller, though still notable. When compared to the Medicare non-hospital rate, prices in doctors' offices are more consistent and closer to the Medicare rate, while hospital outpatient departments show greater price variability and outliers. Additionally, we found significant regional variation in commercial prices relative to Medicare by setting, particularly in Mohawk Valley, North County, and the Southern Tier.

This price difference is primarily driven by the facility fee hospitals can charge, which is meant to cover the costs associated with the facility. However, for these low-complexity services, the facility costs in hospitals should generally be no higher than those in doctors' offices. When we estimated savings from capping both the hospital and non-hospital rates at a percentage of the Medicare non-hospital rate, we found that New Yorkers could have saved $1.14 billion under a cap at 150% of the Medicare non-hospital rate in 2022, $168.9 million to $213.4 million of which would be experienced through lower out-of-pocket spending.

Our findings align with broader economic literature, which consistently shows that prices for routine services delivered in hospital settings are significantly higher than in doctors' offices.[31, 32] One study, for example, found that commercial payments for 89 routine services were, on average, 1.2 to 3.6 times higher in hospital outpatient departments compared to doctors' offices in 2018. Additionally, patient out-of-pocket spending for these services was about 20% of the total price. The study estimated that US commercial insurers and their members could have saved $1.2 billion in 2018 if these services, when delivered in hospitals, were paid at the median office rate.[33] Another study, which estimated potential savings from setting payments for the MedPAC recommended services at the median commercial office or ASC price for each ambulatory payment classification—a category of procedures reimbursed through the outpatient prospective payment system—found that such a policy would have saved

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[31] Medicare Payment Advisory Commission. Chapter 8: Post-acute care. In: Report to Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission; June 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf. Accessed Nov 4, 2024.

[32] Post B, Norton EC, Hollenbeck B, Buchmueller T, Ryan AM. Hospital-physician integration and Medicare's site-based outpatient payments. Health Serv Res. 2021 Feb;56(1):7-15. doi: 10.1111/1475-6773.13613. PMID: 33616932; PMCID: PMC7839648.

[33] Sen AP, Singh Y, Anderson GF. Site-based payment differentials for ambulatory services among individuals with commercial insurance. Health services research. 2022 Oct;57(5):1165-74.

commercial insurers $58.2 billion in 2022.[34] Our findings differ in that they are specific to New York State and use capped rates set as a percentage of the Medicare non-hospital rate across all settings. These caps are based on estimated costs to provide the services, rather than the average or median commercial office rate, which can be influenced by insurer-provider bargaining leverage.

VI. Conclusion

Site-neutral payment reform is a viable, bipartisan strategy at both the state and federal levels to address rising health care spending. Extensive research, including the findings in this report, has shown that routine services performed in hospital outpatient departments are reimbursed at significantly higher rates than when provided in doctors' offices. There is a lack of clear evidence that these higher payments correlate with improved quality. While site-neutral reforms have been considered for Medicare at the federal level, states are taking the lead in addressing the site-of-care payment disparity in the commercial market, most notably through an initiative led by the 32BJ Labor Industry Cooperation Trust Fund in New York State. Our analysis estimates that this initiative, which proposes to cap rates at 150% of the Medicare non-hospital rate, would have saved New Yorkers $1.14 billion in 2022, with $168.9 million to $213.4 million of those savings benefiting consumers through lower out-of-pocket spending. These efforts are a critical step toward broader site-neutral payment policies that promote fair and equitable pricing across health care settings.

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[34] Parente ST. Impact of Site-Neutral Payments for Commercial and Employer-Sponsored Plans. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2024;61. doi:10.1177/00469580241275758

I. Appendix

Appendix Methods

Calculating commercial and Medicare payment rates

We took several steps to determine commercial and Medicare payment rates in the hospital outpatient department (HOPD) and lowest-cost settings. In the office setting, only professional fees are paid to the rendering or billing physician, allowing us to identify the full payment using professional claims. In most cases, this involved a single claim line. However, in some instances, the professional claim was split into two components: the professional fee for the services provided by the physician and the technical component covering practice expenses. In these cases, we combined the claim lines to calculate the total payment. For the HOPD and ambulatory survey center (ASC) settings, we identified both the professional and facility claims and combined these payments to determine the total payment for each service.

We also calculated the Medicare-equivalent payment in the lowest-cost setting. For evaluation and management (E&M) services and procedures associated with the 57 ambulatory payment classifications (APC) that the Medicare Payment Advisory Commission (MedPAC) deemed safe to deliver in doctors' offices, we use the Medicare physician fee schedule (MPFS), which identifies procedure-level physician prices by region. For the 9 APCs that can be safely performed in the ASC setting, we calculated the Medicare-equivalent ASC payment, which includes both professional and facility components. We used the MPFS to identify the Medicare professional fee, while the Medicare ASC facility fee was based on the national conversion factor for 2022 ($49.92), adjusted by the hospital wage index. Instead of adjusting at the hospital level, we applied regional wage adjustments due to the absence of hospital identifiers in the Health Care Cost Institute data. We then applied APC relative weights, which reflect the resource requirements for specific services. Additionally, when multiple surgical procedures were performed during the same encounter, we determined the total facility fee by summing the highest payment rate with 50% of the rate for the other procedures.

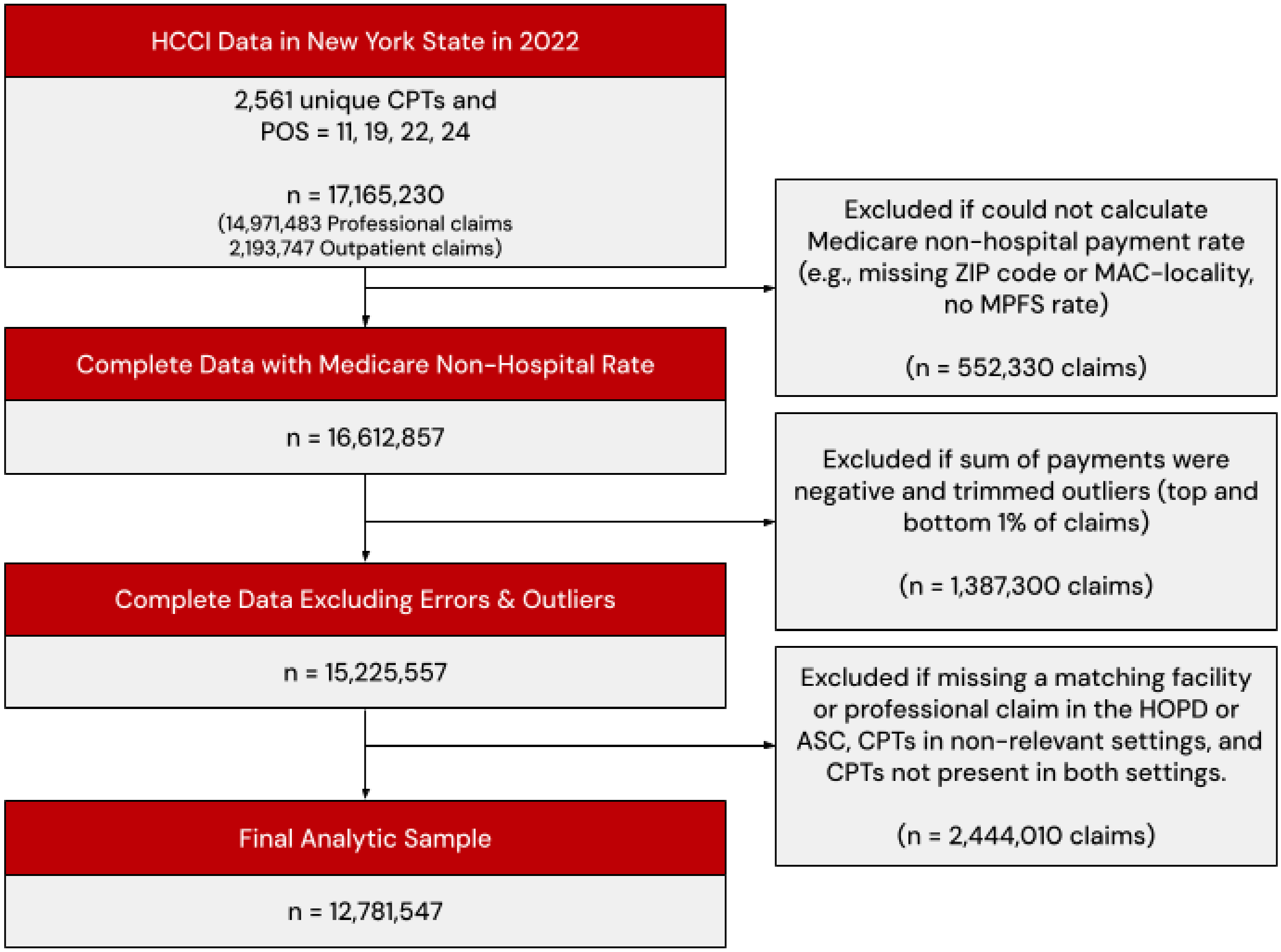
Appendix Exhibit A1. Services Recommended by the Medicare Payment Advisory Commission for Safe Provision in Lower-Cost Settings

Service Type	APC/CPT Code	APC/CPT Description
57 APCs aligned with PFS rates	5012	Clinic visits
	5693	Level 3 drug administration
	5694	Level 4 drug administration
	5524	Level 4 imaging w/o contrast
	5593	Level 3 nuclear medicine
	5522	Level 2 imaging w/o contrast
	5523	Level 3 imaging w/o contrast
	5521	Level 1 imaging w/o contrast
	5052	Level 2 skin procedures
	5691	Level 1 drug administration
	5373	Level 3 urology and related services
	5443	Level 3 nerve injections
	5054	Level 4 skin procedures
	5442	Level 2 nerve injections
	5724	Level 4 diagnostic tests and related services
	5692	Level 2 drug administration
	5441	Level 1 nerve injections
	5722	Level 2 diagnostic tests and related services
	5611	Level 1 therapeutic radiation treatment preparation
	5051	Level 1 skin procedures
	5822	Level 2 health and behavior services
	5053	Level 3 skin procedures
	5734	Level 4 minor procedures
	5071	Level 1 excision/biopsy/incision and drainage
	5372	Level 2 urology and related services
	5723	Level 3 diagnostic tests and related services
	5733	Level 3 minor procedures
	5823	Level 3 health and behavior services
	5101	Level 1 strapping and cast application
	5721	Level 1 diagnostic tests and related services
	5153	Level 3 airway endoscopy
	5731	Level 1 minor procedures
	5371	Level 1 urology and related services
	5671	Level 1 pathology
	5164	Level 4 ENT procedures
	5741	Level 1 electronic analysis of devices
	5055	Level 5 skin procedures
	5481	Laser eye procedures
	5151	Level 1 airway endoscopy
	5111	Level 1 musculoskeletal procedures
	5163	Level 3 ENT procedures
	5732	Level 2 minor procedures
	5743	Level 3 electronic analysis of devices
	5102	Level 2 strapping and cast application
	5161	Level 1 ENT procedures
	5152	Level 2 airway endoscopy

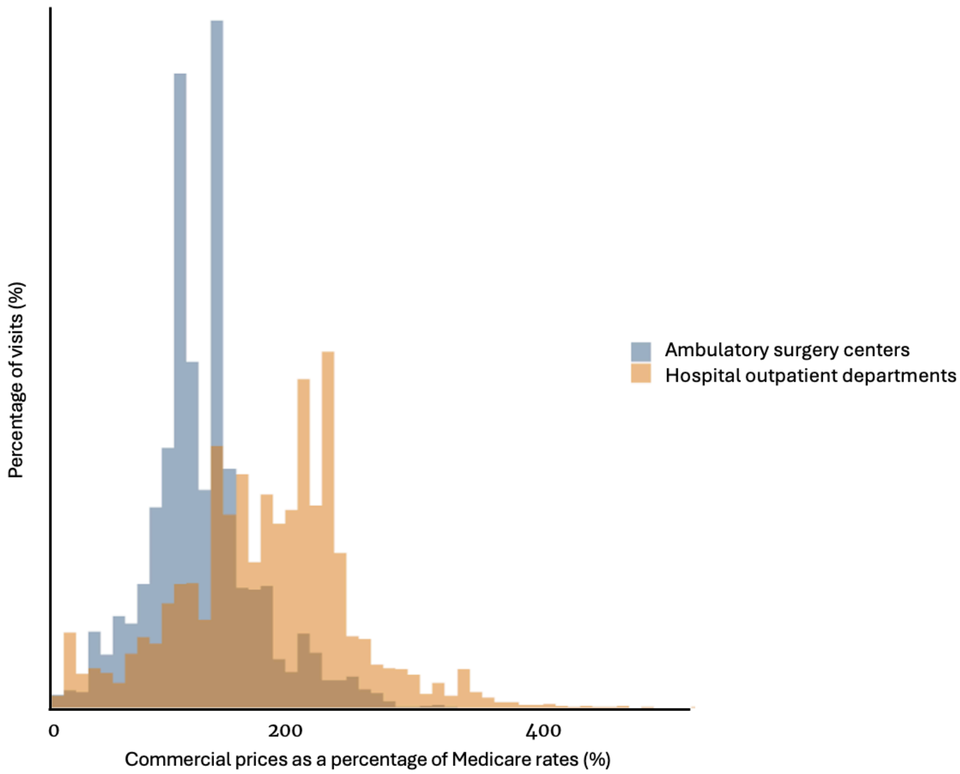
	5413	Level 3 gynecologic procedures
	5411	Level 1 gynecologic procedures
	5412	Level 2 gynecologic procedures
	5162	Level 2 ENT procedures
	5742	Level 2 electronic analysis of devices
	5502	Level 2 extraocular, repair, and plastic eye procedures
	5501	Level 1 extraocular, repair, and plastic eye procedures
	5735	Level 5 minor procedures
	5821	Level 1 health and behavior services
	5621	Level 1 radiation therapy
	5811	Manipulation therapy
9 APCs aligned with ASC rates	5312	Level 2 lower GI procedures
	5491	Level 1 intraocular procedures
	5431	Level 1 nerve procedures
	5311	Level 1 lower GI procedures
	5492	Level 2 intraocular procedures
	5112	Level 2 musculoskeletal procedures
	5462	Level 2 neurostimulator and related procedures
	5503	Level 3 extraocular, repair, and plastic eye procedures
	5504	Level 4 extraocular, repair, and plastic eye procedures
E&M Services	99202	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 15-29 minutes.
	99203	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 30-44 minutes.
	99204	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 45-59 minutes.
	99205	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 60-74 minutes.
	99211	Office visit for an established patient, which may not require the presence of a physician, typically taking 5-10 minutes.
	99212	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 10-19 minutes.
	99213	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 20-29 minutes.
	99214	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 30-39 minutes.
	99215	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 40-54 minutes.

Source: *Medicare Payment Advisory Commission, June 2023 Report*

Appendix Exhibit A2. Consort Diagram



Appendix Exhibit A3. Distribution of commercial prices for low-complexity services safe in ambulatory surgery centers relative to Medicare non-hospital rates across sites of care, 2022



Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *The distribution compares the commercial price relative to what Medicare would have paid in the lowest-cost setting (i.e., non-hospital setting).*

Appendix Exhibit A4. Relative prices and volume by region and setting in New York state, 2022

Region	Service Type	Relative price	Volume
Capital District	Hospital	351%	15,737
	Non-hospital	118%	463,928
Central New York	Hospital	486%	29,261
	Non-hospital	117%	1,293,629
Finger Lakes	Hospital	511%	123,328
	Non-hospital	117%	1,704,285
Hudson Valley	Hospital	500%	22,264
	Non-hospital	143%	1,006,667
Long Island	Hospital	380%	15,452
	Non-hospital	122%	1,297,460
Mohawk Valley	Hospital	678%	25,524
	Non-hospital	108%	362,241
New York City	Hospital	541%	103,655
	Non-hospital	140%	3,465,468
North County	Hospital	725%	22,299
	Non-hospital	105%	197,196
Southern Tier	Hospital	696%	68,922
	Non-hospital	120%	786,531
Western New York	Hospital	276%	33,884
	Non-hospital	105%	1,209,443

Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Note*: Volume is not scaled to the wider commercial market in New York.*

Appendix Exhibit A5. Estimated savings in millions and share of procedures subject to the cap at different cap levels by service type and setting, 2022

Cap at [X%] of Medicare	Service type	HOPD		Lower cost setting (Office/ASC)		Total by service type	Savings as % of total revenue from these services in 2022
		Savings in mill ($)	% of procedures subject to cap	Savings in mill ($)	% of procedures subject to cap		
100%	Patient office visits	19.2	96.7	523.2	53.3	542.4	–
	Other low-complexity services safe in doctors' offices	527.0	98.0	829.0	57.4	1355.9	–
	Low-complexity services safe in ASCs	15.7	89.6	30.6	84.1	46.3	–
	Total by setting	561.9	–	1382.7	–	1944.6	33.5
150%	Patient office visits	15.4	93.1	174.8	16.7	190.2	–
	Other low-complexity services safe in doctors' offices	458.1	94.9	477.7	27.3	935.8	–
	Low-complexity services safe in ASCs	7.5	75.2	7.5	32.0	15.0	–
	Total by setting	481.0	–	660.0	–	1140.9	19.6
200%	Patient office visits	11.8	86.1	57.8	4.3	69.6	–
	Other low-complexity services safe in doctors' offices	392.2	89.9	302.2	15.3	694.4	–
	Low-complexity services safe in ASCs	3.4	46.4	2.1	8.7	5.5	–
	Total by setting	407.4	–	362.0	–	769.4	13.2
250%	Patient office visits	8.7	71.2	23.3	1.6	32.0	–
	Other low-complexity services safe in doctors' offices	332.2	83.2	207.5	8.8	539.7	–
	Low-complexity services safe in ASCs	0.9	13.3	0.4	2.6	1.3	–
	Total by setting	341.8	–	231.3	–	573.1	9.9
300%	Patient office visits	6.1	55.7	9.4	0.7	15.4	–
	Other low-complexity services safe in doctors' offices	279.0	74.5	159.7	5.0	438.7	–
	Low-complexity services safe in ASCs	0.3	5.6	0.1	0.5	0.5	–
	Total by setting	285.4	–	169.2	–	454.6	7.8
350%	Patient office visits	4.0	45.3	4.0	0.3	8.1	–
	Other low-complexity services safe in doctors' offices	233.9	66.9	133.3	3.5	367.2	–

	Low-complexity services safe in ASCs	0.1	2.8	0.1	0.2	0.2	–
	Total by setting	238.0	–	137.4	–	375.4	6.5
400%	Patient office visits	2.5	32.0	1.9	0.1	4.4	–
	Other low-complexity services safe in doctors' offices	195.4	60.2	116.6	2.6	312.0	–
	Low-complexity services safe in ASCs	0.1	0.9	0.0	0.2	0.1	–
	Total by setting	198.0	–	118.5	–	316.5	5.5

Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*
Notes: *APC = ambulatory payment classification; ASC = ambulatory surgery center; E&M = evaluation & management; HOPD = hospital outpatient department.*

Appendix Exhibit A6. Patient cost-sharing and facility vs. professional payment share, 2022

	Mean	Median
Patient cost-sharing on low-complexity services	18.7%	14.8%
Facility portion	84%	88%
Professional portion	16%	12%

Source: *Authors' analysis using 2022 data from Health Care Cost Institute contributors.*