32BJ
LABOR INDUSTRY
COOPERATION

The Need For Fair Hospital Pricing Action In New York:
Issue Brief

All data contained in this paper are derived from 32BJ Health Fund claims data or other cited sources.

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Table Of Contents

Executive Summary

Healthcare spending in New York is both higher than other states and rising more quickly than the national average.[1]

A key driver of those healthcare costs is the higher-than-average prices being charged by New York hospitals and the relentless hospital price increases that have far outpaced other categories of medical inflation.[2] Commercial healthcare spending in New York was $75 billion in 2020.[3] Of this, 39 percent, or $29 billion, was spent on hospital services.[4] Though some hospital services are by nature resource-intensive due to the complexity of treatment required, hospitals are increasingly providing low-complexity, low-intensity services at high prices.

Over the last two decades, big hospital conglomerates in New York have amassed more market power and wealth through consolidation—merging and buying up doctors' offices.[5] This contributes to a dynamic where patients either receive routine care at their usual doctors' office location but now those services are billed as a hospital outpatient department service, or they are more likely to be referred to separate and more expensive hospital outpatient departments. The market power that results from consolidation incentivizes owners to steer patients to receive medical care at their own subsidiaries, leading to a shift in patients' site of care for routine services. Billing as, or referring to, hospital outpatient departments happens even though routine services can be provided safely in less expensive doctors' offices, with no difference in the quality of care.[6,7] Because physicians have been providing these services both effectively and efficiently, the price they receive is a reasonable market standard. Throughout this brief, the term hospital outpatient department refers to a health clinic on a hospital campus or an affiliated off-campus location that provides healthcare treatment to patients that do not require overnight admission. These outpatient departments may appear to operate as regular doctors' offices—physically unchanged from when they were billing as a doctor's office—but can now bill patients using the hospital's tax identification number.

The preponderance of research has shown that vertical and horizontal hospital consolidation leads to higher prices.[8] Increased hospital market power from mergers and acquisitions creates a positive feedback loop—hospitals command higher prices, which incentivizes further consolidation, and creates further price increases. With this type of monopolistic market behavior emerging in the late 1990s and persisting today, policy and regulatory action is needed to mitigate the impacts of increased hospital prices on patients, families, and employers.

The impact of these unnecessarily high hospital prices represents a hidden tax for New York employers, a squeeze on worker wages, and a hardship for New York residents, most of whom share in the cost of their healthcare. It also adds billions of dollars of unnecessary expenditures for New York State and City governments struggling to ensure their employees and constituents have access to the healthcare they need and to provide other critical public services. **Patients and health plans, in New York and nationally, should not be charged higher prices for routine medical care just because of who owns the building.**

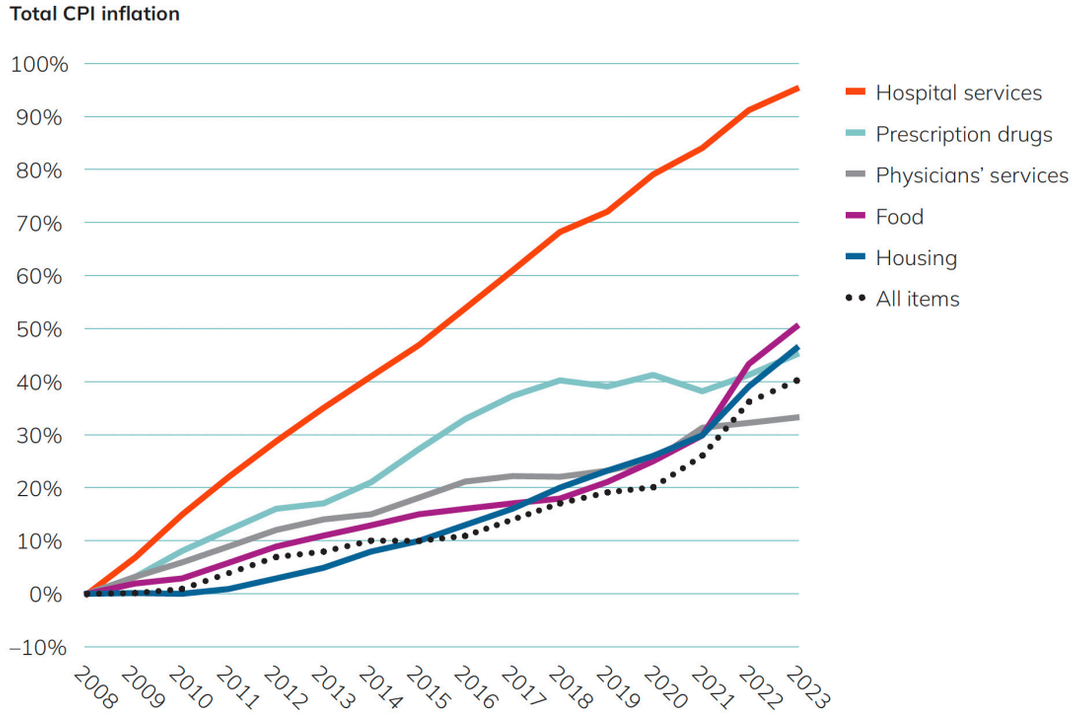
The Fair Pricing Act would make New York the first state in the nation to cap prices for certain routine services rendered at hospital outpatient departments at prices comparable to the rates paid in doctors' offices.

Background

I. Hospital prices are unnecessarily inflated.

Healthcare costs have been rising faster than the rate of inflation,[9] with hospital prices rising faster than any other type of care, including prescription drugs. Nationally, healthcare spending continues to climb, with increases in prices expected to account for nearly half of that growth (as compared to growth in utilization of healthcare, population, or intensity of services needed, based on predictions for 2018-2027).[10] This is true nationally, but particularly in New York State. New York's per–capita spending on hospital care is higher and growing faster than national per–capita hospital expenditures (as of 2020).[11]

Figure 1: Hospital Prices are Driving Healthcare Costs Nationally: Consumer Price Index Inflation from 2008 to 2023



Source: Bureau of Labor Statistics

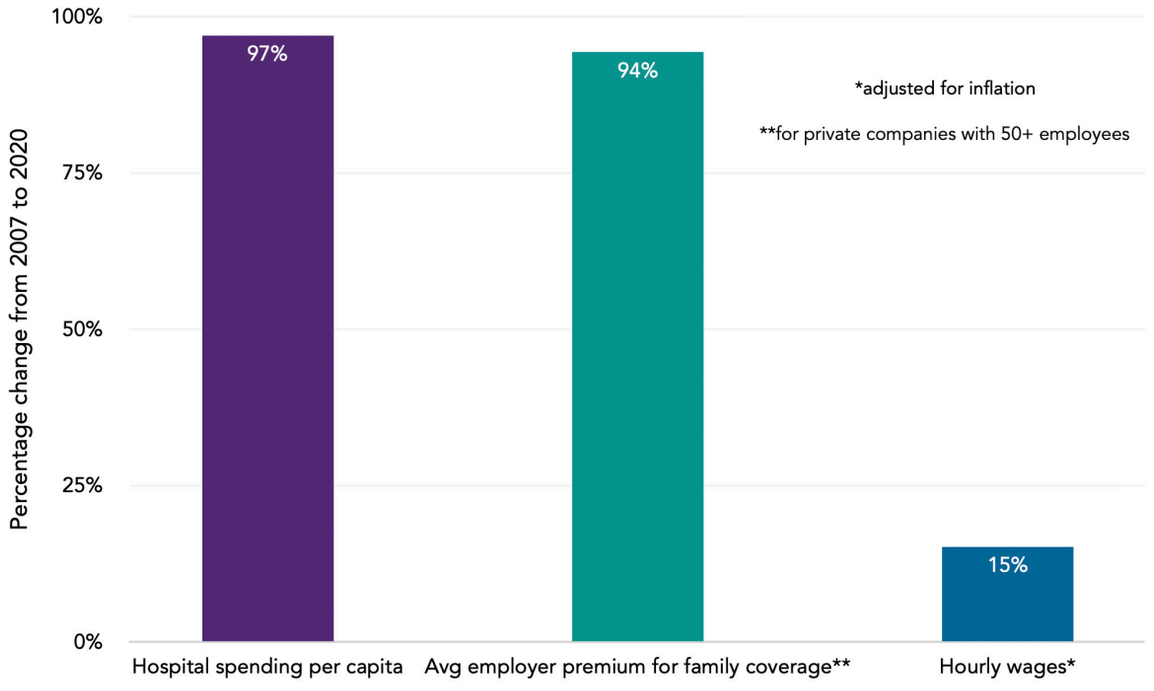
The outsized growth in healthcare costs is not because patients are recieving more or better–quality care. Instead, costs are increasing due to high and rising hospital prices—meaning we are paying more without added value in return.[12] Not only are prices high and increasing for traditional hospital services—such as inpatient or emergency services, but hospitals are also expanding their scope of services to increasingly provide low–complexity, low–intensity services at high prices. Historically, most hospital revenue is from inpatient care, with outpatient services representing only 28% of hospital aggregate revenue in 1994. Today, outpatient services account for around half of total hospital revenue.[13] In an analysis of the healthcare prices charged to 123 million covered lives by an insurer from 2017 to 2022, hospital outpatient prices increased by 27 percent, as opposed to a 11 percent increase for ambulatory surgery centers, and a 2 percent increase for services at doctors' offices.[14]

The prices that commercial insurers pay are far higher, and rising much faster, than the prices paid by public insurers to hospitals. Commercial healthcare spending in New York was $75 billion in 2020,[15] and the hospital sector constituted 39% of that spending.[16] Employers and unions that provide health insurance are paying hospital prices significantly higher than Medicare pays for the same services (by about 250 percent).[17] The federal government determined Medicare rates to be a fair price because they factor in severity, geography, and cost of living, among other things.[18] Price differences between commercial and public payors have not always been so stark—in the 1990s, hospital prices paid by commercial payors were only 10 percent higher than Medicare.[19] During this time (1989-1998) the national hospital all–payer profit margin was 4.8 percent. By 2009–2018, a period of increased hospital market consolidation and the higher payment rates noted above, the national all-payer hospital profit margin increased to 6.4 percent.[20]

Hospitals with the highest prices are not the hospitals that provide the most care for uninsured or publicly insured patients, but rather those that have the most market power.[21] While some New York hospitals are operating in crisis mode, those struggles are not uniform across hospitals, and there are no justifications for hospital price increases that are double that of other medical sectors like prescription drugs. New York's hospitals vary significantly in their spending on meaningful community investment, all while receiving hundreds of millions of dollars in tax exemptions annually.[22]

There are several existing proposals to improve Medicaid reimbursement for hospitals in New York, and many hospitals that serve primarily low–income populations are indeed financially distressed.[23] However, policies that ensure those hospitals can sustainably care for New Yorkers are separate and apart from policies needed to address the crisis of healthcare affordability for individuals, unions, and employers. The healthcare affordability crisis has wide ranging consequences from New Yorkers being sued for medical debt,[24] to New Yorkers avoiding getting medical care due to fears about how much it will cost,[25] to New Yorkers receiving suppressed wages because employers must dedicate significant and increasing revenue to cover healthcare costs.[26]

Figure 2: Rising Hospital Prices and Health Insurance Premiums Compared to Wage Increases: Percent Change in New York State from 2007 to 2020



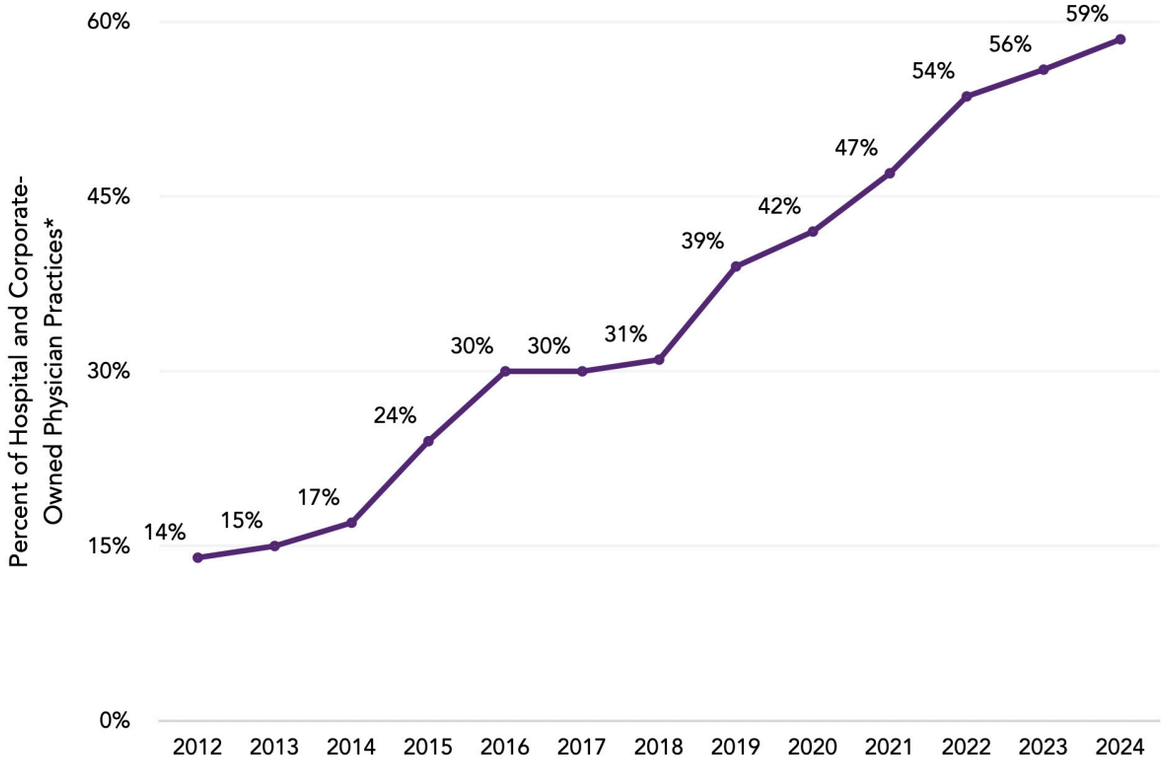
Sources: *Centers for Medicare and Medicaid Services—National Health Expenditure Data; U.S. Bureau of Labor Statistics—Industry and Productivity Costs*

High hospital prices also result in higher public spending on health benefit programs for the state and the city, which are funded by New York State and City taxpayers. New York State provided health benefits to 1.2 million public employees and retirees at a cost of $10.3 billion in 2021, of which $4.2 billion was spent on hospital services.[27] The City has similarly high healthcare expenditures for its workers. In 2022, New York City provided health benefits to over 600,000 public employees and retirees at a cost of $8.8 billion.[28] If New York City's hospital pricing and spending patterns matched the rest of the state, the City could be overpaying by as much as $2 billion annually specifically on hospitals.[29] For both the City and the State employee plans, high hospital prices drive up health benefit costs unnecessarily, squeezing wages and other benefits for public workers, as well as the total budget for public services.

II. Inflated prices at hospital outpatient departments are in part a result of consolidation and provider acquisition.

Nationally, doctors' offices are increasingly being acquired by hospital systems that command higher prices for the same low–complexity services that are safe to provide in doctors' offices.[30] Between 2012 and 2018, the share of physician practices that were hospital-owned more than doubled, and the COVID–19 pandemic only accelerated that trend (see Figure 3).[31,32] As shown in Figure 3 (sourced from two reports by the Physicians Advocacy Institute), the percentage of either hospital– or corporate–owned physician practices rose 20 percentage points from January 2019 to January 2024. The Northeast region experienced the fastest growth of physician practice hospital acquisitions in this time.[33] These acquisitions contribute to market power and incentivize owners to steer patients to receive medical care at their own subsidiaries.[34]

Figure 3: National Data Illustrates Growth of Hospital and Corporate Ownership of Physician Practices



*PAI began tracking corporate ownership separate from hospital ownership in 2019; 2019-2024 data includes ownership by other corporate entities.

Sources: Physicians Advocacy Institute (February 2019). Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018.; Physicians Advocacy Institute (April 2024). Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023. Prepared by Avalere Health.

Unsurprisingly, New York is not immune to the trend of hospital consolidation. A 2018 study of New York hospital consolidation found "the 12 largest systems now control half of all the acute care hospitals in New York and 70 percent of the inpatient acute care beds. Four mega–systems—New York-Presbyterian, Northwell Health, NYU Hospitals Center and Mount Sinai Health System—have accumulated multiple hospitals and a combined total of $14.2 billion in net assets, giving them significant economic power and ability to shape the health system."[35] By the end of 2022, these same four systems had a combined total of over $24 billion in net assets (see Figure 4).[36]

Figure 4: Change in Total Net Assets for New York City Health Systems, FY 2016 vs. 2022

Health System	Total Net Assets, 2022	Total Operating Revenue, 2022	Operating Income, 2022	Change in Total Net Assets, 2016 vs. 2022
New York–Presbyterian	$10,790,927,000	$10,728,145,000	$201,260,000	**63%**
Northwell Health	$6,051,841,000	$15,568,044,000	$117,648,000	**68%**
NYU Langone	$4,785,736,000	$7,376,832,000	$619,176,000	**133%**
Mount Sinai Hospital	$2,730,721,000	$3,694,561,000	$188,624,000	**41%**
2022 Totals	**$24,359,225,000**	$37,367,582,000	$1,126,708,000	

Source: Audited Financial Statements for Financial Years 2022 as posted on Electronic Municipal Market Access and accessed April 2024

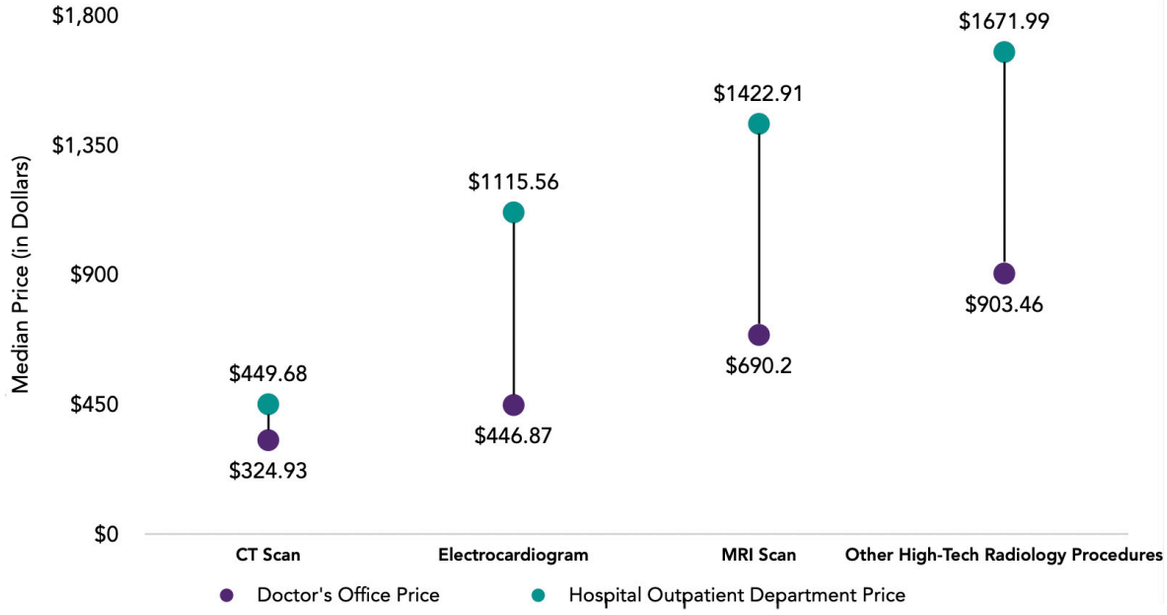
In February 2024, Northwell Health announced a proposal to acquire the Nuvance Health system, which operates seven hospitals in Connecticut and New York State. The proposed merger would expand the Northwell System to include 28 total hospitals valued at $20 billion. This prompted calls from Sean King, Connecticut's state Healthcare Advocate to assess the merger's impact on healthcare prices and market consolidation.[37]

Studies show that both for-profit and nonprofit hospitals increase prices after mergers that lessen market competition.[38] There is significant evidence that vertical acquisitions, when physician's practices are bought by larger health systems or other corporate entities, lead to higher prices.[39,40] In one study, when physician practices were acquired by hospitals, their prices increased by an average of 14%, and the peer-reviewed journal indicated that "nearly half of this increase [was] attributable to the exploitation of payment rules."[41]

III. Prices for the same routine services are often higher at hospital outpatient departments versus doctors' offices.

Higher prices in hospital outpatient departments are a result of both higher base rates paid to hospitals and "facility fees," which are separate bills intended to cover hospital overhead costs. Facility fees are not charged for the same procedures when provided in doctors' offices. These higher base rates are on top of the cost of the services provided by a medical professional. Figure 5 shows the higher prices of radiology services at hospital outpatient departments, compared to doctors' offices, based on 32BJ Health Fund's own claims.

Figure 5: 32BJ Health Fund Claims Show Hospital Outpatient Department Service Prices Are Significantly Higher than Doctor's Office Prices



In addition to price differences, patients generally have higher cost-sharing risk when receiving care in a hospital outpatient department: where they may only have one, lower copay in a doctor's office, they may be subject to higher copays, deductibles, or coinsurance in a hospital outpatient department. For example, a patient's copay for an MRI may be $25 when that procedure is provided in a doctor's office, but $75 if that procedure is provided in a hospital outpatient department.

Patients may not be aware that their doctor's office had been acquired by a hospital system and now bills as a hospital outpatient department, and they may receive a facility fee in a separate bill.[42] Some facility fees are warranted, but not all. Facility fees can have an important role in helping offset expenses required to provide 24/7 emergency care and specialized equipment for complex services only available in a hospital.[43] The application of a facility fee becomes questionable when they are applied to services provided outside of the hospital, or services that do not require hospital-level equipment, such as telehealth or home-based services.[44] While it can be difficult to parse facility fees in claims data, a Massachusetts report showed that average facility fees for basic office visits can be over $1,000.[45] These fees are not prevented or protected by the balance billing prohibitions in the federal No Surprises Act.[46]

IV. Site-specific price differences for routine services create perverse revenue maximization incentives for healthcare providers.

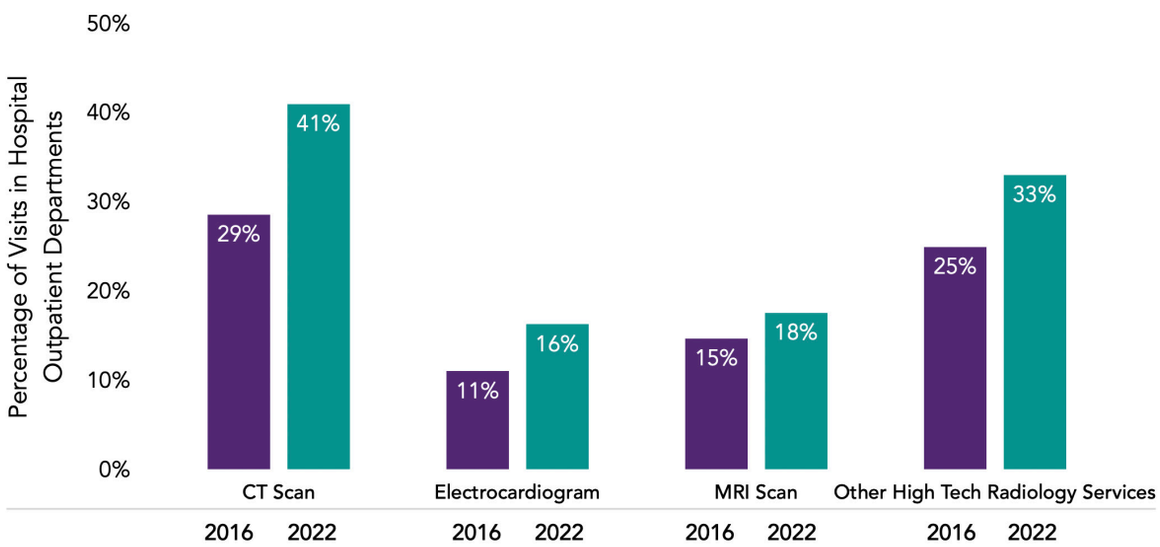
This accumulated market power makes it difficult for employers, unions, and commercial insurers to negotiate lower prices. Historically and presently, certain routine services are reimbursed at higher prices when delivered in a hospital outpatient department versus a doctor's office. This creates further incentive for hospitals to acquire doctor's offices and change their billing status to hospital outpatient departments in order to command higher prices for the same routine services. As a result, researchers have observed a greater portion of these routine services occurring in hospital outpatient departments (versus doctor's offices) over time.

The Medicare Payment Advisory Commission (MedPAC) found, between 2012 and 2015, that the volume of echocardiograms (ECG/EKGs) provided in doctors' offices fell 16 percent, while the volume provided in hospital outpatient departments increased by 20 percent.[47] More recently, between 2015 and 2021, MedPAC also found that the volume of chemotherapy administration provided in doctors' offices fell 14 percent, while the volume provided in hospital outpatient departments increased 21 percent.

In an analysis comparing the medical complexity of patients receiving routine care in hospital outpatient departments compared to doctors' offices, MedPAC found only eight percent of patients at hospital outpatient departments ranked in the highest percentile of medical complexity. This suggests shifting routine care to hospital outpatient departments is not related to increasing patient severity.[48]

The 32BJ Health Fund conducted its own claims analysis to examine changes in billing from office settings to hospital outpatient departments, and the results mirrored the pattern identified by Medicare. The analysis showed a shift over time in the site of care for many routine procedures like allergy shots, acupuncture, and glaucoma screenings from doctors' offices to hospital outpatient departments. As shown in Figure 6, 32BJ Health Fund participants in New York received about 29 percent of non-emergency CT scans in hospital outpatient departments in 2016. By 2022, 41 percent of those same scans were conducted in hospital outpatient departments, rather than a doctor's office.

Figure 6: 32BJ Health Fund Claims Illustrate That Basic Procedures are Shifting to Hospital Outpatient Departments (from 2016 to 2022)



V. The shift toward hospital outpatient departments compounds price differences into huge costs for employers, unions, and consumers.

Shifting care to hospital outpatient departments costs more for individuals and the employers and unions who pay for healthcare, with no clinical reason to justify this shift. As shown in Figure 5, the median price the 32BJ Health Fund pays for radiology procedures in a hospital outpatient department is almost double the price of the same service in a doctor's office. If non-emergency CT scans provided in New York's hospital outpatient departments had the same price as in doctors' offices in 2022, the 32BJ Health Fund could have saved over $600,000 on that procedure alone. Claims for electrocardiograms (ECG/EKG) revealed a similar pattern – if the median hospital outpatient department price for ECG/EKG in 2022 matched the median doctor's office price, the 32BJ Health Fund could have saved $1.3 million for plan participants in New York State. If all services that Medicare has determined are safe to provide in doctors' offices were priced at the average doctor's office rate instead of the hospital outpatient department price for all 32BJ Health Fund participants, the 32BJ Health Fund could have saved $31 million in 2022.

Without action to mitigate the price differences between settings, services may continue to shift towards unnecessarily expensive (and sometimes inappropriate) hospital outpatient departments—further exacerbating healthcare costs.

In a recent hearing by the Massachusetts Health Policy Commission, between 2019 and 2022, hospital outpatient departments had the fastest annual growth (eight percent) compared to any other hospital-based site of care (inpatient or emergency department), and compared to doctors' offices, urgent care, or pharmacy care.[49] This type of shift will continue to increase commercial spending and inflate hospital prices.

Hospital prices should be based on the resources needed to treat patients safely, efficiently, and with high quality. There is no evidence to justify higher prices to hospital outpatient departments for certain low-complexity services, given that high prices are not correlated with better quality care.[50] When hospital outpatient departments charge more for the same procedures, working people and employers shoulder the burden of the healthcare affordability crisis.

"There is no evidence to justify higher prices to hospital outpatient departments for certain low-complexity services, given that high prices are not correlated with better quality care"

What Policies Are Aimed At Reducing Inflated Hospital Prices?

VI. Several states have attempted to eliminate facility fees.

Several states have recently passed legislation to eliminate certain facility fees: Connecticut, Colorado, Indiana, and Maine are the most prominent examples.[51] These pieces of legislation require increased transparency of facility fees to determine which services should or should not have a facility fee attached.[52] New York passed legislation in 2022, which became effective in June 2023, banning facility fees for preventative care and requiring patients to be notified about facility fees before they are charged (if the fees are not covered by insurance).[53] However, eliminating facility fees does not comprehensively address the market failure described above for two reasons: facility fees alone do not account for higher base prices in hospital settings, and facility fees are difficult to distinguish within overall prices in accessible hospital payment data, making these laws difficult to enforce. State laws to eliminate facility fees do not address the fact that more patients are being referred to hospital outpatient departments for low-complexity procedures, where the base prices (including professional fees) are higher than in doctors' offices. Additionally, the elimination of facility fees does little to stop providers from shifting higher prices to professional or other fees.

VII. Medicare reimburses the same price for the same procedure regardless of setting for certain services.

In November 2015, the Federal Bipartisan Budget Act included provisions that lowered Medicare reimbursements for evaluation and management (E&M) services provided in hospital outpatient departments. This was intended to create parity for Medicare rates paid to hospital outpatient departments and doctors' offices, based on a March 2012 MedPAC recommendation.[54] Although this was a good start, many facilities were exempt from the law, and new hospital outpatient departments were grandfathered into pre-existing hospital campuses.[55] In June 2023, MedPAC recommended that Congress more closely align payment rates across ambulatory (outpatient) settings with the rates paid in lower cost settings, such as doctors' offices. MedPAC's 2023 recommendation focused on services that are safe and clinically appropriate to be provided in a doctor's office including X-rays, MRIs, and administration of IVs.[56] There was fierce hospital lobby opposition, and Congress has not yet acted on the MedPAC recommendation. In December 2023, the U.S. House of Representatives passed the Lower Costs, More Transparency Act, which would ensure Medicare pays the same prices for physician-administered drugs in different settings.[57]

However, in March 2024, the bipartisan legislation stalled in Congress.[58] Due to Congressional gridlock in deliberations and industry lobbying, fair pricing proposals will likely not be passed in the near term at the federal level.

Fair Pricing Legislation In New York

With Congress's current inability to pass significant healthcare pricing reform, it is up to state legislatures to act to protect patients, families, unions, and employers from high prices. In 2022, the New York legislature advanced legislation toward making healthcare more affordable by banning facility fees for preventative services,[59] and passed the Hospital Equity and Affordability Law (HEAL), which prohibited certain anticompetitive contracting clauses between healthcare providers and insurers.[60] With the the Healthcare Data Transparency Act (HDTA) being signed into law in December 2023, the Department of Civil Service will now be required to produce a report with hospital– and procedure–specific information on prices, which will provide further insight on state healthcare expenditures.[61] Despite these important steps toward greater transparency, fundamental issues in hospital pricing remain. These laws have not yet been able to address the inflationary effects of consolidation that have already occurred.

Though New York, along with seven other states, used to have a hospital rate-setting body for inpatient care, all but one (Maryland) were dismantled in the 1990s. Current New York State laws do not regulate commercial prices for routine healthcare procedures. New York's legislature must act to change hospital systems' incentives to continue acquiring doctors' offices and charging higher prices for basic healthcare services.

The Fair Pricing Act would make New York the first state in the nation to cap prices for certain routine services rendered at hospital outpatient departments at prices comparable to doctors' offices.

VIII. Fair pricing policies in New York can generate billions in savings for payors, patients, and taxpayers.

Payors (Employers, Unions, and Commercial Insurers)

Enacting a policy to set the same price for routine procedures regardless of setting would reduce costs for payors while preserving quality of care and creating minimal patient disruption.[62] If a fair pricing policy were in place for all 32BJ Health Fund participants using the set of procedures identified by MedPAC in 2012 and 2023, the 32BJ Health Fund would have saved approximately $31 million. This accounts for approximately two percent of the Health Fund's total health benefit expenditures in 2022. Applying the same savings percentage to New York's estimated statewide commercial health insurance market total annual health benefit spend – approximately $75 billion – statewide savings could equate to $1.5 billion in one year if fair pricing were applied.[63,64,65] For context, four of the largest academic hospitals systems in New York City reported total net financial assets of $24 billion in one year (see Figure 4).[66] The Committee for a Responsible Federal Budget estimates commercial payors could save between $140 and $466 billion in the next 10 years if this type of policy were implemented nationwide.[67]

Patients

Adopting a policy to cap prices for routine procedures would lower out-of-pocket costs for patients.[68,69,70] Among commercially insured patients, benefit designs can have different cost-sharing structures for hospital-based services (including services at hospital outpatient departments) versus doctors' offices, so patients may benefit from lower copays or coinsurance costs when services are performed in a doctor's office. Reduced incentives for hospitals to continue acquiring doctors' offices may also reduce the costs of patient care in the long term. Research suggests this kind of policy would reduce out-of-pocket

costs most for patients with high medical needs and chronic illnesses, particularly those who use hospital outpatient departments regularly for services like chemotherapy administration.[71] For self-pay patients, there are clear benefits for lowering the price of routine services regardless of what setting they are provided in.

In addition, lower healthcare costs can lower health insurance premiums, which can free up savings for workers through wages and other benefits. A recent study suggests that premium costs from families using employer-sponsored health insurance has resulted in cumulative lost earnings of over $125,000 per family in the U.S. from 1988 to 2019.[72]

This policy would not affect continuity of, or access to care for patients.

To the contrary, it would reduce disruption of care if the legislation reduces market incentives to acquire doctors' offices or to make referrals to more expensive hospital outpatient departments for services that could be provided safely and effectively in a doctor's office. This could also increase patient satisfaction, by allowing individuals to continue seeing longstanding doctors rather than being directed to new, more intensive care sites for routine procedures.[73]

Providers

While more research is necessary to predict the impact of a fair pricing policy on specific hospitals, for four major New York City hospital systems, projected savings from this type of fair pricing legislation represent between 2 and 5 percent of the 32BJ Health Fund's total spend at those hospital systems. Based on 32BJ Health Fund's analysis, the impact on safety net hospitals and public hospitals would be significantly less. Based on 32BJ Health Fund participants' use of the eight non-profit facilities in the NY Safety Net Hospital Coalition,[a] savings from this type of fair pricing legislation would represent 0.7 percent (less than one percentage point) of the Health Fund's total spend at those hospitals. The effect on public hospitals is even less; savings from this type of fair pricing legislation would represent 0.3 percent of the Health Fund's total spend at those hospitals.[b]

Reducing the incentive to refer to hospital outpatient departments may increase volume to doctor's offices, but more research is necessary to determine the specific impact on doctors. Fair pricing can also reduce incentives for further health system and practice consolidation, which may improve competition in the healthcare market to the benefit of doctors.

National physician organizations support maintaining fair and affordable pricing for routine healthcare. The American Academy of Family Physicians, a national association of independent doctors, publicly endorsed congressional efforts to pass fair pricing federal legislation in 2024.[74]

Public Budgets

Fair pricing reforms also have the potential to produce municipal and state budget savings. In New York State and City, lowering healthcare costs for public employee health plans can help alleviate budget shortfalls and other constraints on public spending. As referenced above, New York State spent $10.3 billion on health care for its public employees and retirees in 2021 under its New York State Health Insurance Program (NYSHIP) plan.[75] If the NYSHIP plan experienced the same proportion of savings 32BJ Health Fund estimates for this policy (approximately 2 percent of total health benefit spend), NYSHIP could save an estimated $206 million in one year. The same is true for the City's employee health plans. Having spent $8.8 billion in 2022,[76] the City could save an estimated $176 million in one year if fair pricing legislation were passed. More research is needed to determine what savings may be possible for state-subsidized commercial plans, like the Essential Plan.

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a. This includes Brookdale Hospital Medical Center, Flushing Hospital Medical Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, SBH Health System, St. John's Episcopal Hospital, and Wyckoff Heights Medical Center.

b. This includes the 11 NY Health + Hospitals facilities, as well as Eerie County Medical Center, Nassau University Medical Center, and Westchester Medical Center.

Conclusion

New Yorkers continue to be burdened with astronomically rising healthcare costs, driven by high and rising hospital prices.

When hospitals raise prices on routine medical care provided in hospital outpatient departments that is safe to provide at a doctor's office, the added costs are shouldered by patients, families, workers, employers, and payors. Current policies and research suggest promising opportunities to make routine healthcare pricing fairer and more affordable for all New Yorkers, without comprising access or quality of care. While more research is necessary to determine the detailed economic impacts of enacting a fair pricing policy, it is clear the time to reform hospital outpatient pricing for routine care is now.

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