



Suburban  
Hospital Alliance  
of New York State, LLC

# OPPOSITION MEMO

**Date: May 8, 2026**

**To: Senate Health Chair Rivera**

**Members of the Hudson Valley and Long Island Senate Delegations**

**From: Wendy Darwell, President & CEO**

**Re: S.705B (Krueger) – on May 12 Health Committee Agenda**

The Suburban Hospital Alliance of New York State, representing hospitals and health systems on Long Island and in the Hudson Valley, is strongly opposed to S.705B/A.2140B, which would sharply reduce reimbursements for care provided at hospital-owned outpatient departments, as well as clinics, physician practices and ambulatory surgery centers. This will result in reduced access to care in community-based settings, the impact of which will hit vulnerable patients the hardest while padding insurers' profit margins.

### **Far exceeds scope of Medicare policy.**

S.705B/A.2140B, the so-called "Fair Pricing Act," would cap reimbursements by all non-Medicare payers at 150 percent of the Medicare rate for most services provided at outpatient sites. Although the bill purports to mimic Medicare, which has implemented site-neutral payments for a limited subset of services, this legislation would go far beyond that. It would extend site-neutral payment to a list of procedures once recommended by a Medicare advisory board but explicitly rejected by policymakers and regulators.

### **Interferes with free market negotiations.**

This legislation also is notably different from the Medicare policy in that the target of capped payments would be commercial insurance rates. This interferes with the free market right of healthcare providers and health plans to negotiate the terms of their contracts. Health plans are not victims in such negotiations – even the largest health systems are not on a level playing field with the multi-national, for-profit giants that dominate New York's insurance market. Even in a less competitive market than New York's, hospitals are price takers, not price setters. It is up to health plans to determine what the market will bear and for providers to determine the reimbursement rates that they can afford to accept.

### **Health systems are not driving physician practice acquisition – for-profit entities are.**

The legislation also is purportedly intended as a response to non-profit health systems' acquisition of physician practices in recent years. However, health systems are far from the top drivers of physician practice acquisition; according to a study conducted for the American Hospital Association by Levin Associates, 65 percent of practices acquired between 2019 – 2023 were purchased by private equity-backed entities. Health system acquisitions, at 6 percent, are fourth in line behind larger physician groups and health plans. In fact, Optum Health – a subsidiary of UnitedHealth Group – is now the largest employer of

physicians in the country, representing about 10 percent of the physician workforce. Optum will keep the premium dollar whether this law is enacted or not.

**Higher reimbursement rates for hospital-owned practices are justified by enhanced regulatory burden, requirement to serve all patients.**

Reducing reimbursement for hospital-owned practices or equalizing those rates with physician practices ignores the significant expenses uniquely incurred by hospitals. Unlike private physician practices, Article 28 facilities must meet more stringent life and fire safety codes, have emergency preparedness, infection control and quality reporting requirements that physician practices do not, and must accept all patients, regardless of insurance coverage or lack thereof. Consequently, hospital or health system-owned clinics treat a sicker, more complex patient population than a typical private practice. Privately-owned practices, surgery centers and urgent care clinics can and do cherry-pick their patients.

**S.705B/A.2140B would fundamentally alter the economics of health care, to the detriment of underserved populations and for the benefit of health plans' profit margins.**

The trend of hospital acquisition of physician practices has been explicitly driven by public policy at the state and federal levels through under-reimbursement by government payers, the need for vertical integration to better coordinate care and achieve quality metrics, and the push to extend services into underserved communities. It's essential to eke out an operating margin on some services to offset underpayment by government payers and reinvest in services.

Medicaid only reimburses hospitals in the suburban regions about 67 cents for every dollar it costs to provide care; Medicare is 90 cents. The two primary ways that healthcare providers can offset decades of underpayment by public insurers and still manage to keep their doors open are by achieving economies of scale and shifting costs to commercial payers. As both the share of services covered by public payers and the number of uninsured New Yorkers grow, this will become more imperative. With capped commercial reimbursements, health systems would be unable to maintain many of their current services – both inside hospitals and at community-based sites. Insurer- and private equity-backed outpatient practices will not serve the same population if they cannot make money doing so.

The legislation inherently proves this point by carving out distressed and safety net providers from the mandate. Such providers are struggling precisely because they treat a disproportionate share of Medicare, Medicaid and uninsured patients and so lack the ability to shift costs to commercial payers. The Fair Pricing Act will only increase the number of distressed providers, increase health plan profits, and reduce the availability of services for disadvantaged populations.

**Uncertainty of ongoing federal funds threatens all providers**

The timing of this legislation could not be worse. Healthcare providers and the State of New York are facing sharply reduced federal support for our healthcare system as a result of last year's budget reconciliation legislation. When the law is fully implemented, hospitals face \$8 billion a year in cuts. The numbers of uninsured and underinsured patients already have increased, along with hospitals' charity care obligations. More uninsured patients, compounded by likely reimbursement cuts, will make healthcare providers more financially fragile. Enacting government-mandated price caps on commercial payer rates will only hasten this crisis.

For these reasons, we urge you to oppose S.705B/A.2140B.