New York City Council

Committee on Hospitals | Committee on Health

Hearing Testimony:
"Cost Disparities between New York City's Voluntary Hospitals"

David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy

GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Rivera, Chair Levine, and other members of the Health and Hospitals Committees, my name is David Rich, Executive Vice President for Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA). GNYHA's members include all of the hospitals in New York City, both public and voluntary, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

Unique among health care providers, hospitals are available 24 hours a day, 365 days a year, during the times of New Yorkers' greatest need, saving lives at every moment of every day. Also unique among health care providers, our hospitals and their staff take care of New Yorkers in need regardless of their ability to pay and their insurance status. Our hospitals, both public and voluntary, serve huge numbers of Medicaid patients and provide the same quality of care to all. The extraordinary health care infrastructure our hospitals have developed benefits all of us. Our hospitals are also the economic anchors of their communities. Indeed, New York City hospitals are the largest non-public sector employer in the City.

Hospital pricing is an extremely complex topic. Hospitals cover the cost of delivering 24/7 patient care, the other benefits they provide for their communities, and, critically, the salaries and benefits they provide for their union and non-union employees, through a patchwork quilt of payments from government payers—Medicare, Medicaid, Child Health Plus, etc.—and private payers, usually through rates that each hospital has negotiated with each insurance company or, sometimes, with self-insured plans and union benefit funds. Self-insured plans and union benefit funds are often administered by huge, national, for-profit insurance companies, who negotiate rates with hospitals. If a hospital has no contract with an insurance company the hospital bills the insurer based on its standard charges for each service provided and then, often, a price negotiation ensues. There is no legal requirement that insurers or self-insured plans pay the amount hospitals charge—only that they hold their members harmless—and very often insurers pay considerably less after months of negotiations.

Each insurance company has different rules that govern their negotiations with hospitals, some set nationally at corporate headquarters in other states. And as the Federal and State governments have encouraged or mandated Medicare and Medicaid patients to enroll in private insurance plans, the complexity has further increased.

The American Hospital Association has put it this way:

> There are more than 1,300 health plans, plus many more employers who self-insure for employees' health care, in addition to public payers such as Medicare, Medicaid and the Department of Defense. **Each of these payers offers a range of insurance products – types of health plans – and each product can have different combinations and permutations of covered and excluded services, patient cost-sharing, payment schemes and rules.** Hospitals must comply with payers' requirements for preauthorization and admission notification, as well as utilization review and reporting requirements.
>
> Unfortunately, there is no standard set of requirements that hospitals must follow; each insurer can set its own requirements as well as change those requirements at any time without consultation with the hospitals that must comply with them. Further, as payers change patient cost-sharing

arrangements – introducing high-deductible health plans, health savings accounts, multi-tiered coinsurance tied to provider rankings – hospitals are devoting more administrative resources to billing activities, making changes to their claims processing systems, and helping patients understand their coverage.[1]

All of these factors can influence the prices that hospitals negotiate with insurers. No two negotiations are the same, and prices differ from insurer to insurer, even for patients utilizing the same hospital. Negotiated rates for one hospital may even differ for enrollees of the same insurance company but who are enrolled in different insurance plans, e.g., a preferred provider organization plan versus an HMO, closed network plan.

The New York City hospital marketplace is a highly congested and extremely competitive one, perhaps the most competitive in the country. According to U.S. News and World Report, "The greatest concentration of standout regional hospitals lies in the New York metro area."[2] Given our competitive market, near-monopoly concentration, which has been cited as the reason for high hospital prices in other regions of the country, is not an issue in New York City. In New York City we have six major hospital systems[3], several world-renowned specialty hospitals[4], and a number of hospitals that are more loosely affiliated. All are competing for patients; consequently, insurers in many cases have the luxury of designing narrow networks that may include some hospitals but exclude others. This ability of insurers to play hospitals and systems off each other has an effect on negotiated rates.

There is also a huge mismatch between the size and scope of many of the insurers hospitals must negotiate with and the hospitals themselves. Our hospitals—all public or not-for-profit—are negotiating with several behemoth, national, publicly-traded insurance companies such as Anthem (known in New York as Empire), UnitedHealthcare, and Aetna. These companies have huge resources, and, unlike our hospitals, who answer only to their patients and communities, they must answer to their shareholders. They are hugely profitable, and their profits have been soaring. UnitedHealthcare reported profits of $3.3 billion in the third quarter of 2018 alone, a 28% increase over third quarter 2017.[5] Anthem, Empire's parent, reported $960 million in profits in the third quarter, up 29% from the same quarter last year.[6] Similarly, Aetna reported third quarter profits of $1 billion.[7] ***These third quarter profits are larger than the entire annual budgets of many of our hospitals and health systems.*** Our hospitals' resources are a drop in the bucket compared to the resources of these for-profit companies. These huge insurers have maximum incentive to pay the lowest possible prices to health care providers so they can provide a return to their investors. They thus drive very hard bargains, and then engage in practices—such as payment denials for medically necessary services—to avoid or postpone payments to hospitals as long as possible.

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[1] American Hospital Association, "Issue Brief: Hospital Price Transparency," May 4, 2018, www.aha.org. Available at https://www.aha.org/system/files/2018-05/ip-pricetransparency.pdf.
[2] U.S. News & World Report, 2018-19 Best Hospitals.
[3] The six systems are Montefiore Health System; Mount Sinai Health System; NewYork-Presbyterian Hospital; Northwell Health; NYC Health + Hospitals; and NYU Langone Health.
[4] These include, for instance, Memorial Sloan Kettering Cancer Center and Hospital for Special Surgery.
[5] https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UNH-Q3-2018-Release.pdf
[6] https://www.marketwatch.com/story/anthem-raises-earnings-guidance-2018-10-31
[7] http://investor.aetna.com/phoenix.zhtml?c=110617&p=irol-newsArticle&ID=2374056

Aetna, for instance, has been unilaterally reducing payments to hospitals for specious reasons. Our hospitals find that they have burdensome, unreasonable administrative policies and procedures that lead to inappropriate denials and underpaid claims. They and their counterparts purposely engage in practices designed to delay or reduce hospital payments. **Aetna's practices prompted us to file a complaint with the New York State Department of Financial Services, and lead us to express extreme doubts about their proposed merger with CVS.** Anthem (Empire) also is seeking to slash payments to hospitals and has engaged in many questionable practices, including **reducing payments to hospitals for newborn deliveries if the delivery wasn't preauthorized**, refusing to pay for imaging services provided in hospital settings, and sending payments for emergency services to their enrollees and then forcing the enrollees to make payments to the hospitals—or forcing the hospital to seek full payment from their patients. All other insurers send payments directly to providers, taking the consumer out of the process.

While these behemoth companies nickel and dime our hospitals to death, by contrast, hospitals in New York City—voluntary and public—provide care to all New Yorkers of all income groups. They are there for all of us in emergency situations, no questions asked. Unlike in other states, where most hospitals are not Medicaid providers, all of our hospitals provide high-quality medical care for Medicaid patients. The great health care infrastructure our hospitals have created benefits all New Yorkers.

Other factors that can influence the rates hospitals negotiate with insurers include:

- **Medicare and Medicaid Underpayments:** Neither the Medicare nor the Medicaid programs cover the cost of caring for their enrollees. In order to make up the difference and stay afloat, hospitals must, if they can, negotiate higher rates with commercial insurers to cover the losses from public programs. Not all hospitals have enough privately-insured patients to achieve this cost-shift, which is the cause of the financial distress we have seen among our inner city safety net hospitals.
- **Community Benefits:** New York's hospitals provide a plethora of unreimbursed or under-reimbursed benefits for their communities, including emergency care for all regardless of ability to pay; school-based health clinics; ambulatory care networks; training of physicians, nurses, physician assistants, pharmacists, and other health care professionals; cutting-edge research that leads to cures and saves countless lives; and others. During the Ebola scare in 2014, New York City asked a number of our hospitals to spend millions of dollars each to create facilities that could handle Ebola patients. This effort went completely unreimbursed. The ability for hospitals to afford to provide these benefits is directly related to the reimbursement rates they can negotiate with both public and private payers.
- **Teaching vs. Non-Teaching:** Academic medical centers and major teaching hospitals incur the costs of training the physicians of tomorrow. In order to do this, they must have highly trained faculty and attending physicians that they must attract from all over the world and the latest technologies for physician residents to learn from. Our hospitals are competing with teaching hospitals all over the country for the best and brightest physicians, specialists, and faculty. Due to this expertise, they also care for the sickest and most complex patients that non-teaching hospitals often do not have the experience to care for. All of this makes a teaching hospital's operations more expensive, and reimbursement rates must reflect this expense. New York State had a pool of funds to help reimburse teaching hospitals, paid for by private insurers; however, that pool no longer pays

for graduate medical education costs. Thus, hospitals must negotiate rates to cover these public goods.

- **Reputation for Quality Care and Qualitative Differences:** Some hospitals in New York City have national and even international reputations for providing quality care. These hospitals have invested heavily in making sure they provide high quality services, have the latest technologies and capital equipment, including, for example, telemedicine, and the best physicians and surgeons. Due to this, New Yorkers often show a preference for these hospitals, and demand that their insurers contract with them and include them in their networks. This dynamic has an impact on contract negotiations as well.

As you can see, there are many reasons that rates hospitals have negotiated with insurers can differ from hospital to hospital and from insurer to insurer. What is clear is the old adage: you get what you pay for. Hospitals must be able to cover their costs and the losses they incur from caring for Medicare and Medicaid patients. If they cannot, not only will they be unable to provide unreimbursed community benefits; invest in technologies, cutting edge research, and expert professional staff; and afford the generous union contracts they have negotiated for their employees, they will not survive.

Therefore, we call upon the City Council to support their local hospitals.

I am happy to answer any questions you may have.

Testimony
Sara Rothstein, 32BJ Health Fund Director
November 19, 2018

Good afternoon,

I am the Director of the 32BJ Health Fund, a multiemployer plan that provides benefits to union members of SEIU 32BJ and their eligible dependents.

Our plan participants have health insurance premiums are that are fully funded by employers that negotiate with SEIU 32BJ. The Fund is jointly governed by a board of trustees appointed by the Union and the Employers. We provide benefits to 200,000 people across 11 states, but most are in the NYC metro area.

Our Fund is self-insured, which means that the Fund, not an insurer pays for all medical claims incurred by our members. We design the benefits – what is covered and what the out of pocket costs are. We use a Third Party Administrator (Empire BlueCross BlueShield) to provide a network and adjudicate claims. We pay them a flat administrative fee. They aren't paid more if our members use more services or if we pay higher dollar amounts for care. Empire negotiates rates with providers (hospitals, doctors, labs, etc) but we pay all of the bills for all services.

Contracts between Empire and its providers are confidential. We aren't privy to the contract terms and cannot influence the terms of those contracts even though they relate directly to the costs paid by the Fund. We get claims data and analyze the data, so we know where people go for care and what we pay each time they use their benefits

After an analysis of our claims data in which we looked at several common inpatient and outpatient services, we determined that for these types of care, on average, we pay more at NYP than for the same care at other hospitals.

- Their 13 hospitals include
    - NewYork-Presbyterian Allen Hospital
    - NewYork Presbyterian Brooklyn Methodist Hospital
    - NewYork-Presbyterian/Columbia University Medical Center
    - NewYork-Presbyterian David H. Koch Center
    - NewYork-Presbyterian Hudson Valley Hospital
    - NewYork-Presbyterian Komansky Children's Hospital
    - NewYork-Presbyterian Lawrence Hospital
    - NewYork-Presbyterian Lower Manhattan Hospital
    - NewYork-Presbyterian Morgan Stanley Children's Hospital
    - NewYork-Presbyterian Queens
    - NewYork-Presbyterian/Weill Cornell Medical Center
    - NewYork-Presbyterian Westchester Division
    - Gracie Square Hospital

Examples of types of care in which we, on average, paid more at NYP than the average for comparable care at other NYC hospitals

- On average we paid NYP $82,843 for hip replacements. That's $25,000 more than we paid, on average, for the same procedure at other NYC hospitals.
- On average we paid NYP $56,858 for bariatric surgery. That's $11,000 more than we paid, on average, for the same procedure at other NYC hospitals.
- On average we paid NYP $23,635 for vaginal childbirth deliveries. That's nearly $7000 more than we paid, on average, for the same procedure at other NYC hospitals.
- On average we paid NYP $10,929 for cataract surgery. That's more than $6000 more than we paid, on average, for the same procedure at other NYC hospitals.
- On average we paid NYP $8,151 for colonoscopies. That's more than $5,000 more than we paid, on average, for the same procedure at other NYC hospitals.

In our analysis, we selected procedures where there is minimal clinical variation in how they are performed. This minimized the need to risk adjust (e.g., adjust the numbers if one population was healthier or sicker than the other), but we nevertheless took several steps to risk adjust our findings. The price discrepancies remain even after risk adjustment.

These significant cost differences are important because every time the Fund – or any other health plan – pays more for care than it has to, it undermines the long-term stability of our health plans and our ability to provide meaningful health coverage to our members.

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Testimony of Kyle Bragg, 32BJ SEIU Secretary Treasurer

Good afternoon Chairs Levine and Rivera and Committee Members. My name is Kyle Bragg and I am the Secretary Treasurer of 32BJ SEIU.

As you know 32BJ SEIU represents over 90,000 hardworking New Yorkers. We take real pride in the quality of health care benefits we have won for our members. These benefits include premium-free family coverage, low copays, and a network of thousands of doctors that have real life-changing impact in the quality of life of our members.

Unfortunately, these benefits are jeopardized by skyrocketing New York hospital costs. Our Health Fund has analyzed its data and found real differences in what they pay for the same care at different hospitals.

The significant disparity in prices for the same care at different hospitals lacks rational justification. I can't understand why Health Fund has to pay an average of $83,000 for a hip replacement at New York-Presbyterian but an average of $58,000 at other hospitals.

Millions of dollars are being lost when hospitals can overcharge us for care. We need to find a solution. These higher prices are hurting our members. Every dollar that goes to benefits is a dollar that doesn't go to wage increases. But this problem also has implications for hundreds of thousands of New Yorkers who participate in self-insured plans.

This comes in the context of Presbyterian threatening to leave a network that insures nearly 3 million New Yorkers. Planned care for 32BJ members and others at Presbyterians would become prohibitively expensive because of high charges.

Until we started talking to our members and the public about this issue, no one knew that there was so much variation in what we have to pay hospitals. Hospitals demand that their contracts and rates be kept secret. This is crazy. What kind of market-based healthcare system we have when you can't compare what you are buying before making such an important decision?

We know there is a problem and we are calling on all elected officials in New York to find solutions to this problem. I want to thank the Council for holding this hearing and helping bring transparency to the health care market.

My name is Rich Iorio and I'm a 32BJ member. I work at East River Houses on 530 Grand Street.

- My union 32BJ works hard for all of its members so that we can win strong contracts with real benefits.

- My family relies on the health coverage and my good union job.

- Our benefits are at risk because of the increased cost of Hospital care.

- The staff at the 32BJ health fund work hard to keep our care affordable. That is why I don't understand why care at NY Presbyterian is so expensive.

- I ***heard that one year our fund paid $10,929 to Presbyterian for cataract surgery. At other providers the cost for the same surgery is $4,252.*** As a union member I want to know why it is so expensive - since those costs affect thousands of other members.

- The more we have to pay for benefits - the less there is for our wages. Working families in this City need every dollar - we can't have healthcare institutions overcharging us when we are trying to make ends meet!

- I want to thank the Council for holding this hearing. You are helping union households.

- I call on NY Presbyterian to do the right thing for millions of New Yorkers and work to get costs under control immediately.

My name is Miguel Santos and I'm a 32BJ member. I work as a commercial office cleaner at 1290 Avenue of the Americas

- I work closely with the union to make sure that our victories lead to fair wages and benefits.

- Health insurance is so important to our members and that is why we keep fighting to keep costs down, while keeping the quality of care high.

- I am here today because I am really worried about health care. Our benefits are at risk because the cost of care at NY Presbyterian is way too high.

- We all work together to keep costs down and that is why I think NY Presbyterian should have fair prices for care.

- ***I learned from the health fund that an outpatient procedure like an MRI costs on average $997 at other NY Hospitals. At Presbyterian it costs $2,419.***

- If healthcare gets too expensive - then winning strong contracts with wage increases will get even more difficult.

- I want to thank the New York City Council for its leadership. We need transparency and fairness in healthcare costs. I ask that hospitals like NY Presbyterian treat union members and NYC residents fairly. We need fairness and honesty from our health care providers.

Testimony at the Health Committee jointly with Hospital Committee Oversight - Cost Disparities between New York City's Voluntary Hospitals.

November 19, 2018

Good afternoon,

My name is Anthony Feliciano; I am the Director of the Commission on the Public's Health System (CPHS). We believe in putting the public back in public health. For over 25 years, we have been addressing inequities in the care, treatment, delivery and distribution of health care services, programs, and resources. We like to thanks the City Council Hospital Committee and Health Committee for holding this hearing today on cost disparities within New York City Voluntary Hospitals.

We want to begin with saying that disparities are also found in the quality and care provided by the health care system. Where some of New Yorkers are already well served, others are in desperate need of access and better care [1]. I would state that as of yet there's no direct correlation between cost and quality. This makes even more complicated that hospitals can charge wildly different prices for similar care. For example, the State produced reports comparing costs for specific common diagnoses. The median cost of a patient discharged in 2014 after a cesarean delivery with minor severity ranged from $18,620 reported by NY Presbyterian Downtown to $6,985 at Mt. Sinai Roosevelt. It is super complicated to explain why care at one hospital appears to be nearly three times the cost of care at another. But we can say they are several factors contributing to the disparity.

1. Enormous reported cost differences reflect differences in the ways the two institutions allocate and report costs. The disparity is only exacerbated because of nonpublic data from health insurers and negotiated contracts with New York State hospital.
2. Bargaining power when negotiating with insurers in the prices a hospital can command
3. Shameful politics by the hospital and insurance Industry, which includes impeding any real progress around transparency of costs for services and accountability to consumers, especially include caring for communities with huge socio-economic issues and problems, most commonly framed as Social Determinants of Health
4. Interpreting New York's data on variations in cost because of flaws in metrics around overall volume, teaching hospital status, facility specific attributes, geographic region and quality of care provided.

A report, funded in part by NYSHealth, examines the factors behind New York State hospitals' wide price variation, with some hospitals up to 2.7 times more expensive than the lowest-priced ones in the same region. It is important to identify cost-effective hospitals — to find the most and least expensive hospitals in the New York City metropolitan area. But it is equally or more critical to understand that Hospitals with higher prices do not necessarily have higher quality. Likewise, hospitals with lower prices do not necessarily have lower quality. We have over several years' large consolidations and mergers of hospital resulting in New York City health care system being delivered by five very large health systems not including NYC Health + Hospitals. Some of those large voluntary systems have the highest facility Cost Ratings like NYU Langone Medical Center but also safety grades of D or worst. I would admit that there are some low-cost hospitals who also have bad safety grades, but not nearly as many of those hospitals that have high costs associated with their inpatient and outpatient services.

Although, NYC H+H system is not the topic of discussion, the entire health care system of NYC is reliant on its ability to take care of all New Yorkers, regardless of ability to pay. I would note that The NYCH+H System's cost structure is sensibly efficient and its care of good quality. The assumptions are untrue related to that public hospitals are less efficient, costlier and of lower quality than voluntary/private service providers. In fact, New York State Nurses Association report on Restructuring NYC Health + Hospitals demonstrated through research of data that NYCH+H costs for treating patients are comparable to or lower than those of voluntary hospitals. For example, surveys by the Leapfrog Group, which is a national hospital industry quality measure organization that rates hospitals on a set range of patient safety metrics, have consistently found that NYCH+H hospitals as a group provide higher than average quality.

NYCH+H increasingly picks up the costs of a wide range of services and populations that private sector providers can avoid exactly because NYCH+H is there to shoulder this responsibility and still charge less for many services than their voluntary provider counterparts. But to get to the bottom of this disparity of cost amongst the voluntary providers can be very complicated because any of the readily-available metrics and accounting methods have shortcomings in providing an accurate picture. This includes the formula that uses the ratio of charges (or list prices) for inpatient to outpatient services performed to create a variable named "adjusted discharge. As many of the states and federal methodologies could be underestimating difference between public and private and even between private providers and private providers that are true safety-net institutions (providing disproportionate amount of inpatient and outpatient care to people on Medicaid and Uninsured). Although

much of the power lies in the state government, we would recommend the following for the City Council to take lead on:

What do we recommend:

- The NYC Department of Health, City Comptroller office along with the City Council could jointly conduct an analysis comparing the actual cost to care for a similar patient in different hospitals. Currently the city DOH does review together both hospital institution-wide cost (ICR) and patient-specific discharge data (SPARCS). However, it may need some other reliable variables that can be married to current data collected. This is important because costs derived from billing data are based upon what is submitted by a facility to the state and may not necessarily reflect a final price of the service delivered.

- Conduct an investigation into hospitals with high cost services for common diagnoses that are also displaying lack of services to low-income, immigrant and communities of color, especially for self-pay/uninsured individuals and families.

- Assess the social and economic impact of the City of New York providing $669 million in real property tax exemptions to private nonprofit healthcare providers. The City and State should reconsider the tax benefits, permitting, and zoning exceptions awarded to private, voluntary hospitals if is not about caring for the sick and the creating fair costs for services and treatment.

- Create a citywide stakeholder group that has equal representation of community advocates and consumers, health facilities and insurance plans to discuss a true path for transparency around costs and quality of care. I would include both City and State Departments of Health to the stakeholder group. In addition, the stakeholder group must be open to the public to attend.

- City Council should monitor closely all the hospitals and health plans to ensure that validated measures do address both disparities in cost and care, especially as medical care reimbursement transitions from fee-for-service to value-based purchasing.

CPHS does acknowledge that there are several voluntary hospitals that are good actors in playing a critical role in serving the uninsured and people on Medicaid (i.e. Interfaith Medical Center, Brookdale and others). However, several private hospital networks operate with huge surpluses and would be important to know if they have enormous price differences from those least flourishing (noting it's sad that health care is about profits). The large private hospitals have grown into multi-site healthcare networks and have positioned themselves to benefit from changes in the healthcare sector. The combined net revenues of the five major private hospital networks were $877 million in 2016, up by over one-third from $650 million for all five in 2014 and 2015.[2] The five large voluntary networks benefit from tax-exempt status despite providing extremely high salaries and pay packages to their executives. So it should be only right that disparity in cost of care between them should be fixed and abide to set of fair principles.

In conclusion, we thank again Councilmember Levine, Chair of the Health Committee and Carlina Rivera, Chair of the Hospital Committee and the staff and members of both committees.

See sources:

1. Roos Tikkanen et al. Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations. NYS Health Foundation March 2017.

2. 2010 Instructions Institutional Cost Report (NYSICR) https://health.data.ny.gov/api/assets/329F8BC6-D396-4902-A9C2-F6B27E143924?download=true

3. NYSNA Report "ON RESTRUCTURING THE NYC HEALTH+HOSPITALS CORPORATION" https://www.nysna.org/sites/default/files/attach/419/2017/09/RestructuringH%2BH_Final.pdf

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