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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON HOSPITALS JOINTLY
WITH COMMITTEE ON HEALTH

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A P P E A R A N C E S (CONTINUED)

Catalina Cruz
New York State Assembly Member

David Rich

Leslie Moran

Andrew Gounardes
New York State Senator

Kyle Bragg

Cora Opsahl

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SERGEANT AT ARMS: Recording to the computer under way.

SERGEANT AT ARMS: Thank you.

SERGEANT AT ARMS: Cloud recording is up.

SERGEANT AT ARMS: Thank you.

SERGEANT AT ARMS: Backup is rolling.

SERGEANT AT ARMS: Thank you, and Sergeant Lugo, with your opening statement.

SERGEANT AT ARMS LUGO: Good morning, everyone. Welcome to today's remote New York City Council hearings of the Committees on Hospitals jointly with Health. At this time would all panelists please turn on your videos. To minimize disruption, please place electronic devices to vibrate or silent. If you wish to submit testimony, you may do so at testimony@council.nyc.gov. Thank you for your cooperation. Chairs, we are ready to begin.

CHAIRPERSON RIVERA: [gavel] Good morning. I am Carlina Rivera, chair of the New York City Council's Committee on Hospitals. And today the Committee on Hospitals is joined by the Committee on Higher Education and my colleague, Chair Mark Levine, to conduct oversight on hospital costs and the impact

on access to care. And I'd like to acknowledge that we have been joined by Council Members, ah, Moya, Holden, and I'm sure that we will be joined by others along the way. I see Council Member Powers and Ayala. So good morning again. I am Council Member Carlina Rivera. I am chair of the Committee on Hospitals. I want to thank you all for joining us today to discuss hospital costs and access to care. Healthcare costs are under constant scrutiny and for good reason. The United States spends more on health care than any other country in the world. In 2019 the United States spent 17.7% of its total GDP on health care, totalling 3.8 trillion dollars, or over $11,500 per person. I'd like to repeat that total again. 3.8 trillion. This is an incredible figure, and while the United States has some of the best healthcare facilities and doctors in the world, we also have the highest prices, the largest cost sharing for patients, and still we do not have the best health outcomes. We do not have universal health coverage and people still experience barriers to care. So how did we get here? Healthcare financing is an extremely opaque and complex topic, an issue that spans over a century. For much of the

US healthcare's system history insurers and providers, including hospitals, were allies. Blue Cross and Blue Shield, the nation's largest health insurance system for 50 years, was formed in part by the American Hospital Association and was in part run by state medical societies affiliated with the American Medical Association. This directly impacted costs. Providers sent generous rules of payment. Blue Cross and Blue Shield made the payments without much pushback and commercial insurers usually followed the same payment rules. This helped fuel rapidly rising healthcare costs, which were not critically examined until the 1970s. Starting then, various and numerous cost control measures took shape. Nowadays there is much tension between providers and insurers, as well as businesses who wanted more affordable health insurance options. All parties want competitive markets to keep their patients or enrollees happy and to keep their own respective costs down. What remains is a pricing system that is unregulated by the government and largely kept out of the public eye, with prices varying greatly, depending on the location as well as the type of insurance a person has. So this led to

recent federal regulations ordering hospitals to publish a complete list of prices that they negotiate with private insurers. And although most hospitals have ignored the rule, the data that is available confirms what has been reported and studied for many years. Hospitals charge patients very different amounts for the same basic services. The data shows that insurance coverage and which hospital one receives care in can shift costs by thousands of dollars. Notably, there are several examples of major health insurers, including some of the world's largest companies with billions in annual profits negotiating unfavorable rates for their customers with instances of insured patients receiving care that is more expensive than if they would have pretended to have no coverage at all. A study by the 32BJ Health Fund analyzed data from hospitals in the greater New York City area and they found that the majority of them failed to fully comply with the new regulations. And while New York City Health and Hospitals was the most compliant, private nonprofit hospital systems, including Mount Sinai, Montefiore, Northwell, New York-Presbyterian, Memorial-Sloan Kettering, and NYU Langone were less compliant or

fully noncompliant. In fact, no hospitals within the Northwell, Memorial-Sloan Kettering, and NYU systems reported their prices. Despite many hospitals' lack of compliance with the federal rule we know that there are significant differences in overall price levels among city hospitals, even those of similar sizes that provide similar services, regardless of the health status of the population served and the complexity of the services provided. What we also know is that high costs directly impact access to care, that affordability and access are intertwined. In 2019 about one in 10 adults reported that they delayed or did not get care because of costs. Delaying or forgoing medical care because of costs disproportionately impacts those who are Hispanic and black, with 15.1% of Hispanic adults and 13% of black adults reporting delaying or foregoing care, compared to 9.3% of white adults and 4.8% of Asian adults. These racial disparities tie into other health inequities, such as insurance status and health status. Even though health insurance can provide protection against unexpected costs, insured individuals can be impacted by high levels of cost sharing and increasing premiums. This oftentimes

leads to an individual or family being underinsured. So people who are underinsured have high health plan deductibles and out-of-pocket medical expenses relative to their income and they're more likely to struggle paying medical bills or to skip care because of cost. In 2019 12.4% of all insured adults reported difficulty paying medical bills. At least one-fourth of insured adults report difficulty affording their deductible, the cost of health insurance each month, or their co-pays for doctor visits and prescription drugs. So this is why we're here today, to critically examine hospital costs and how that directly impacts people who need care. The figures I've highlighted are completely unacceptable, and as a city and as a country we should strive for a more equitable, affordable, and higher-quality healthcare system. I look forward to our robust discussion, and I would like to thank the Hospitals Committee staff, counsel Arhabany Ahuja, policy analyst Ann Balkin, finance analyst Lauren Hunt, and data analyst Rachel Alexander. I also want to acknowledge that we have been joined by other members of the council. It includes Council Members Darma Diaz, Inez Barron, and Selvena Brooks-Powers. I will

now turn it over to my cochair for remarks. Chair Levine?

CHAIRPERSON LEVINE: Thank you so much, Chair Rivera, for the excellent opening statement and your leadership on this issue. Again, I'm Mark Levine. I am chair of the City Council's Health Committee, and I'm pleased to be jointly chairing this hearing this morning. The alarmingly fast rate of increase in healthcare costs has been a source of enormous concern for years in New York and nationally. We had a hearing on this exact topic three years ago and it remains more pressing than ever. The US spends more per capital on health care than other developed nation and will soon spend close to 20% of its GDP on health. It's not that Americans are buying more health care overall than other countries, it's that what we are buying is increasingly expensive. Today in this hearing we want to focus on a key driver of this vexing problem - the fact that some healthcare providers in the city stand out with costs that exceed even the already-high rates of their peers. Recent news coverage and several studies have shown that costs for similar or even exactly the same procedures can vary widely

between different hospitals in New York City, in the same borough, or even just a few blocks away from each other. And what's worse, despite the recent change to federal law requiring more transparency, there is also major discrepancies between hospitals in terms of how upfront and transparent they are about the cost of the services they provide. This hearing will explore the extent to which are costs are being inflated by the opaque hospitals price their services, a problem exacerbated by the hidden details and agreements between insurers and providers. And we will seek to understand while some hospitals are compliant [inaudible] federal hospital choice price transparency rule while others are not. We will also examine the extent to which rapid consolidation of the hospital sector in New York has accelerated the trend for price increases, with the largest systems now acquiring such strong negotiating power that they can block insurance contracts that steer patients to lower-cost providers. The wealthiest New Yorkers can afford the most expensive care. But for working people runaway costs are inflicting a heavier and heavier burden. This is particularly true for workers and their families who

receive their health coverage from a labor union health fund, where higher health costs inevitably lead to lower salaries. To that, to that end we are very concerned to learn that recent [inaudible] labor union with over 200,000 regional members was forced to drop the entire New York-Presbyterian health system from its network because of the hospital's ballooning pricing. For reference, the union's fund paying on average 358% more than Medicare for the same services across the hospital system's facilities. What could possibly explain such inflated costs for services? So we have some high-stakes questions to explore at this hearing, and I very much look forward to our discussions and thank you all for being here. I look forward to hearing from the Greater New York Hospital Association as well as our labor representatives and representatives from the state insurance plans. I want to turn it over now to our hearing moderator, Ann Balkin, to review some procedural matters.

MODERATOR: Thank you. Um, thank you, Chairs. My name is Ann Balkin. My pronouns are they, them, and I am the senior policy analyst to the Committee on Higher Education and the Committee on

Hospitals for the New York City. Before we begin I want to remind everyone that you will be on mute until you are called on to testify, when you will be unmuted by the host. I will be calling on panelists to testify. Please listen for your name to be called. I will periodically announce who the next panelist will be. We will call on individuals one by one to testify and each panelist will be given three minutes to speak. After I call your name a member of our staff will unmute you. There may be a few seconds of delay before you are unmuted, and we thank you in advance for your patience. Please wait a brief moment for the Sergeant at Arms to announce that you may begin before starting your testimony. Council members who have questions for a particular panelist should use the raise hand function in Zoom. I will call on you after the panel has completed their testimony in the order in which you have raised your and. And as a reminder, all hearing participants should submit written testimony to testimony@council.nyc.gov. I would like to now call on our first panel to testify, um, so I would like to welcome David Rich, followed by Leslie Moran. David, you may begin when ready.

CHAIRPERSON LEVINE: Ann, Ann, I'm, I'm so sorry.

MODERATOR: Oh, yes.

CHAIRPERSON LEVINE: And I don't know if Chair Rivera is OK with this, but, ah, our Assembly Member, ah, Catalina Cruz has to leave momentarily. If, if it's OK with Chair Rivera and, and Mr. Rich I'd love to just let her very briefly deliver some remarks. Are you OK with that?

CHAIRPERSON RIVERA: Absolutely [inaudible].

CHAIRPERSON LEVINE: OK, thank you.

ASSEMBLY MEMBER CRUZ: Thank you.

CHAIRPERSON LEVINE: So, Assembly Member, yes, please, take it away.

ASSEMBLY MEMBER CRUZ: Thank you. Um, I want to thank you all for having me, ah, join you today. I think the, the rising cost of health care is something that pertains not just, ah, the folks at the local level, but those of us at the state, and I, you know, and I hope that our federal, ah, counterparts are listening. I know they passed, ah, legislation to force the hospitals to do the right thing, but it hasn't worked. Unfortunately, for the

hospitals it is more profitable to continue to bill our community members exorbitant fees and they increased, ah, the insurance while they paid their $300, ah, fine as a cost of business. Um, I happen to represent, ah, Jackson Heights, Corona, and Elmhurst, which are communities that were hard hit by COVID, um, where the cost of health care is something that we feel every day, and myself have been hit with $12,000, ah, bills, even though I'm ensured, and we are here today because the insurance companies, ah, have tried to work with the hospitals. The unions have tried to work with the hospitals. The government has tried to tell the hospitals what is the right thing to do and they're obviously not listening, because our community members are still having to make choices between, ah, what to pay, do I pay for my healthcare, where do I choose to get that healthcare, and even what insurance to have. Do you have a hospital like New York Presbyterian where you can have one procedure be billed in three different ways to three different insurance companies, and we're talking $20,000, $30,000 difference. And it's because these companies, these corporations that we call hospitals, have chosen to make money out of

health care, have chosen to make money of out allegedly saving lives. And, yes, they're saving the lives. But I say allegedly because when you get a $200,000 bill that you have to pay or when you have to choose between a world-renowned doctor at one hospital versus a decent doctor at another one, you're playing with your health care. You're playing with your life. So we at the state level are going to be joining, or have already joined this fight for our community, for our consumers, for our healthcare, ah, by pushing the HEAL Act. This is an act, ah, that is going to make sure that these exorbitant fees that none of us are privy to, because hospitals keep it under wraps, become something that's public, that we are forcing the hands of the hospitals to do the right thing, to make sure that we get the choice of where to go as a, as a consumer, as a patient, um, which insurance to use, which hospital to use, and not be forced to choose our health care based on what we can afford. That's not the kind of a country we should be. That's not the kind of country that I want to live, be a part of, and we're gonna fight against that. Um, and, and, and before I go, earlier today we had, we had a rally with, with members of

labor. And it made me think about all the thousands of New Yorkers who may not be in a union, but are under the same attack, the attack on your pocket by an industry that has chosen health care as a way to make money. And it made me be thankful for colleagues like you who are fighting for, for these New Yorkers to make sure that after the year we've had, I think now we know what we've always suspected, and that health care is a profitable business that, ah, the, um, that at the expense of many of our family members they are, ah, creating quite the racket to make money and this has to stop. I don't want to be here three years from now asking the same questions. I don't want to hear excuses from many of these hospitals. I want to hear solutions and answers, and I hope that my colleagues at the local level will be able to support, ah, the bill that my colleague, Senator Gianaris, and I are pushing to create that transparency to force the hands of the hospitals and to put the power back on patients and on consumers. And with that I'm gonna leave you, and thank you for the opportunity to be with you today, and let's put people first, let's put patients first over money.

MODERATOR: Thank you so much, Assembly Member. Um, I want to make sure that the chairs don't have any questions before moving on. OK, seeing none, um, thank you so much. So we will move on to our next panel, which will include David Rich, followed by Leslie Moran. So, David, you may begin when ready and once the sergeant cues you.

DAVID RICH: Yes, thank you. Can you hear me? You can hear me OK?

UNIDENTIFIED: Yes, we can hear you.

DAVID RICH: Ah, yes. Ah, hi. David Rich of the Greater New York Hospital Association. As you know, we represent all of the hospitals in the city and across the state, as well as in, ah, neighboring states as well. I just have to say, something I just heard saying hospitals allegedly save lives. In the last 18 months the hospitals in New York City saved New Yorkers from the COVID-19 epidemic, pandemic. They worked 24/7. No other institutions did that. Their staff, from administrators to 1199 workers to NYSNA workers sacrificed extremely hard, made sacrifices barely anybody else in the city made to save people from COVID-19. And for someone to, in this hearing, I'm

sorry to be so upset about this, to say hospitals allegedly save lives, they save lives every day, and this pandemic is not over. And unfortunately while the pandemic continues there are going to be a number of people following me testifying here today who have held rallies to bash those hospitals during the pandemic. And I'm sorry, I, I feel like that's not the way we deal with each other in a community like New York City. They have saved thousands and hundreds of thousands of lives, and at great cost, emotional cost, sacrifice, financial cost. The idea they're making money, hospitals are barely breaking even because of all of the high costs during the pandemic. While for-profit insurance companies who supposedly, according to the last speaker, are working with hospitals and trying, are making billions and billions of doctors. So I'm sorry, I just can't let this allegedly save lives, when they're saving lives even as we speak, go. Now, to the topic at hand, ah, we've testified on this a few times before, but I think we need to recognize that placing all the blame for healthcare costs on hospitals is extremely myopic. Hospitals have the same cost pressures that all the other people in the

healthcare community have. Who purchases more high-cost pharmaceuticals than hospitals do? They suffer from the high cost of pharmaceuticals. They purchase more pharmaceuticals than any other entities in the city, in the state, in the country, and those are very high cost. Some of those pharmaceuticals they purchase only hospitals purchase in order to save people's lives. And manufacturers have a monopoly on some of those. So they're very high cost. They have high cost of medical devices, machinery, walk into an ER, all of those are extremely expensive. They have all of these costs. They have very high health insurance costs. They use the revenues that they make to pay for health insurance with no co-pays and no deductibles for their thousands and thousands of union employees as well as nonunion employees. Um, so they have very high cost of health insurance, and meanwhile the insurance companies, like United Health Care, despite the high cost of health care, made profits of 22.4 billion dollars last year and 12 billion this year. Empire, which is a part of Anthem, their profits were 6.2 billion in the year of the pandemic in 2020. Where is that money coming from? If it's not going to the high cost of health

care, it's not going to pay for their enrollees, so the idea that it's hospitals, hospitals have costs. They have huge costs, like everybody does. Pharmaceuticals, and New Yorkers don't blame hospitals for the high cost of health care. We did a poll in July along with 1199, our partners, ah, that found that, ah, 63% of New Yorkers blamed pharmaceutical companies and 68% blamed insurance companies. They don't blame the hospitals. Hospitals have the same high-cost inputs that everybody does. They don't just, they don't spend nothing and then just come up with prices to charge people. They have to cover costs through Medicare payments, Medicaid payments, both of which grossly underpay for the cost of care, and so if they can they need to try to and shift some of those huge losses for Medicaid to the private sector, if they can, and a lot of our safety net hospitals can't do that, which, as you know, they're on the ropes. They need to be bailed out by the state on a regular basis. So the idea that hospitals are in a vacuum and are not subject to all the other high costs that everyone in the healthcare system is subject to is just really wrong, and, and I feel like having, you

know, you've had three hearings now focusing on hospital costs and we've yet to have one on how it is that these for-profit insurers can make these huge profits, which hospitals are not making, and yet company about the high cost of health care. Somehow they're making these huge profits. They're taking them out of the healthcare system. They're doing it by not paying the hospitals and doctors. There was a *USA Today* article that I mentioned in my written testimony, just last week, talking about how they owe billions and billions of dollars to hospitals and to doctors because the way they make money is by not paying. So, anyway, I'm sorry to get this emotional, but our community is very emotional. The workers in our community are very emotional. They have been through a year and an a half of saving people from this pandemic and I just feel like using words like hospitals allegedly save lives is really out of bounds. Again, I'm sorry to get so emotional, but it's an emotional time for our community and I'm happy to take whatever questions you might have.

MODERATOR: Thank you for your testimony. Um, we will turn to Leslie Moran and before we do that I just want to acknowledge that we are joined by

Council Members Reynoso and Feliz. Um, and so Leslie Moran you may begin your testimony once you are ready and the sergeant cues you.

LESLIE MORAN: Good morning. Are we good to go here? OK. Thank you. Good morning, ah, Chairperson Rivera, Chairperson Levine, and members of the committee. My name is Leslie Moran. I'm senior vice president of the New York Health Plan Association. We are a not-for-profit organization that represents 28 health plans across the state, and those plans provide coverage to more than 8 million fully insured New Yorkers. On behalf of our member health plans, I want to thank you for the opportunity to address the committees on this important issue, um, looking at hospital costs and the impact that they have on access to care. Our member health plans are committed to the goal of universal coverage and they have a long history of working collaboratively with New York government on efforts to expand access to high-quality, affordable health care. Keeping health care affordable is a major challenge facing many employers and consumers, as has been noted by our chairs. This is especially true now when so many are also struggling with the financial impact of the

pandemic. Um, you've referenced it, the chairs have referenced it, and I do not need to tell you about high cost of healthcare. Um, and I also don't needle, I'm sure I don't need to tell you that New York has some of the highest healthcare costs in the country, or that New York's costs are significantly higher than the national average. When people talk about the cost of health care their reference is usually the cost of their health insurance. That's been acknowledged. The fact is that health insurance premiums and health care costs are inextricably linked. The growth in the cost of medical care that's charged by hospitals and other providers, increases in the prices of prescription drugs, and even government taxes and assessments on health insurance results in increases in health insurance premiums. By law, and this goes to, um, a guess a comment from Mr. Rich, by law health plans in New York must spend a minimum of 82 cents of every premium dollar on health care. That is a requirement. 82 cents must be spent on direct health care. Of that an average of 42 cents is spent on hospital costs, inpatient, outpatient, and emergency services. So our comments today, we're looking at

the, the, um, the rising cost of hospital costs, provider costs, especially the issues that are related to the increasing, um, provider consolidation and contracting practices and the impact that that has on those costs. I'm sure everyone is familiar with the 2009 report from the New York State Health Foundation and health costs, Health Care Cost Institute that put a spotlight on New York's higher healthcare spending. A key finding of that report was that the spending was driven by ever-rising prices, not by increased utilization. And one area that was highlighted for particularly high growth in prices was hospitals, again both inpatient and outpatient services. Underscoring those findings, there's a growing body of research, a number of which we cite in our testimony, that demonstrates a primary driver of increased provider prices is consolidation of healthcare providers into health systems, which increases their market power. Another similarity of the studies was the conclusion that merger activities had no statistically significant impact on quality. So what can we do? We believe the government can play an important role to improve the current market dynamics. Taking steps to promote greater

accountability of provider transactions, provide increased transparency in provider costs, and restrict contracting practices that harm consumers and employers. Um, our written testimony outlines some of the potential approaches, and very briefly I would highlight three that we talk about. The first, eliminate anticompetitive contracting prices, or practices. This include prohibiting all-or-nothing clauses that require, um, insurers to contract with all facilities within a network, even if there is not a reason for them to necessarily have every single, um, one of those facilities in their, ah, their network. Promoting quality improvements through contracting that's based on quality measures. There's been a, a movement towards value-based payment, ah, arrangements. Those are not as fruitful as, as we all might hope. Um, barring confidentiality clauses that limit consumers' access to information about the prices that are charged, and allowing consumers to use benefit design to encourage them to obtain care at more affordable provider sites. Ah, a second suggestion is enhancing the oversight of provider mergers. Um, requiring annual reporting of provider entities that merge and asking

them or making them hold their prices flat for a three- to five-year period. This would help ensure that the benefits that are ascribed to merger activities, such as promises of lower costs and improved quality, are actually realized. And third, banning hospital facility fees. This would do away with the practice of hospitals imposing facility fees for services that are provided in a hospital or at a facility that is not on the hospital's campus. As I said earlier, the health plan industry is committed to efforts aimed at reining in the factors that drive increases in the cost of care in order to ensure that every New Yorker has access to high-quality and affordable health care. We are committed to working with you and others and the, other policymakers on measures that are directed at these goals. Again, I thank you very much for inviting us to be here today. We appreciate the opportunity to offer our views and our comments and we're happy to engage in further discussions with the council. Thank you.

MODERATOR: Thank you so much for your testimony. We will now turn to the chairs for questions. Chair Rivera?

CHAIRPERSON RIVERA: Thank you so much for being here today and for your testimony. So how do hospitals communicate with patients before they receive care about their potential costs?

DAVID RICH: So they do it in a variety of ways. One of the, um, requirements of the, um, Trump administration law from last year on price transparency was to either post the, um, prices of 300, ah, shoppable services or provide a cost estimator. And what most of our members have done is provide cost estimators on their websites, ah, which was an option they could do in lieu of the, um, 300 shoppable services. I just do want to say that I take exception to the idea that they have ignored the federal rule. It's an extremely complex rule. There are literally millions of codes of negotiated rates and items and services that hospitals provide and it's an extremely hard thing for them to put together. The rule went into effect during the second wave of the pandemic, so there was a lot going on in the institutions at the time. They are trying as hard as they can to comply and I expect that they all will, um, very shortly.

CHAIRPERSON RIVERA: So I just want to, I understand you mentioned the, the federal regulation, but, so, so can you just kind of answer that with a little bit more detail in terms of your communication with patients?

DAVID RICH: Yes. So they have, so what they can, um, point patients to before they actually receive a service, obviously it's a scheduled service and not the many emergency services that hospitals provide day in and day out. If it's a scheduled service they can, they provided cost estimators so that they can help patients understand what the costs will be. Now, we do have to understand when someone goes into a hospital for a scheduled, scheduled service sometimes thing happens, not everything goes right. That's why it's better to go to a hospital than to, ah, freestanding ambulatory surgeon, surgery center for your care because if something should come up during the surgery and they need more hospitals care, then it will be obviously more services provided and it will be the same amount that was estimated before they, um, had the procedure done. But that is how they help provide those costs and, um, and make those costs available to, ah, to, ah,

their patients. These, um, out-of-pocket cost estimators that were part of the, um, Trump administration [inaudible] last year.

CHAIRPERSON RIVERA: So what are the barriers to this communication?

DAVID RICH: Well, there's not a barrier to that communication. What has been difficult is because of the many insurers that we deal with, the different insurance products, um, insurers negotiate different rates, um, and reimbursement levels even with different insurance products. So, Empire, for instance, has a Medicare insurance product, a Medicaid insurance product, private insurance products, HMOs, they have PTOs, and they may negotiate different rates for all of the different items and services, and then you have to multiple that by several different insurance companies, and so it has been a huge undertaking to try and make that, all of that available. One part of the rule was that they have to, um, make available their standard charges, the [inaudible] rule, ever since the ACA, um, was passed in 2010, and so they have done that for very many years. That's not all that helpful to consumers because most insurance companies negotiate

downward from those standard charges and because of financial assistance plans and other things that the hospitals provide, very few people pay those standard changes. But that, that they have posted for quite some time. Um, but they're trying to figure out ways to be as consumer-friendly as possible and those cost estimators, out-of-pocket cost estimators seem to be the thing that consumers can get their hands around and understand best in terms of what the costs may be.

CHAIRPERSON RIVERA: So, I guess, can you speak to why a hospital, all right, so in, in New York State do hospital procedures tend to be reimbursed by private insurers utilizing a fee for service model or can hospitals also receive a more aggregated form of payment?

DAVID RICH: They can receive a more aggregated form of payment, um, called bundle payments, for instance, for a specific type of service. So, for instance, you may get an orthopedic service provided and, and everything might be all the ancillary services associated with the surgery might be part of, you know, one bundled payment. Um, for the most part hospitals and

insurers still do, um, negotiate, ah, using DRGs, diagnostic-related groups, for inpatient services, and that a different type of, um, a different type of payment for outpatient services. But those usually are the diagnostic-related, they usually still use diagnostic-related groups, at least in the city, um, when they are negotiating with, um, with health plans.

CHAIRPERSON RIVERA: Ms. Moran, did you want to add anything to this?

LESLIE MORAN: Ah, I would just add that health plans also have, um, cost estimators for, for the consumers, um, so that before someone has a procedure they can go and look at, um, what their out-of-pocket costs might be. They can also do some comparison shopping. They can also look at what a procedure might cost and Fair Health, which I presume you're very familiar with Fair Health, which is a, um, now national organization that, that, um, helps consumers figure out what their costs are gonna be and also do comparison shopping. So they can look and see what the costs might be in Hospital A versus B versus C. Um, on the down side it may be that not all of those hospitals are in the network, or it may

be that, um, a consumer has a preference for going to one hospital over another. It kind of goes to the point that I made, ah, in my remarks that one thing we think would be benefit is if health plans were allowed to, um, communicate more with consumers about the, the different and, and maybe even steer them towards a facility that might have lower costs and higher quality. Um, but right now some of the contracting practices in place don't allow us to necessarily direct patients based on those types of metrics. So consumers, um, really have to look at what their costs are.

CHAIRPERSON RIVERA: Do estimator, do cost estimators include their deductible?

LESLIE MORAN: Generally speaking, my understanding is yes, a cost estimator, you would put in all the factors of your coverage and you would, um, you would see what your costs for a procedure were and then you would have to know if you've met your deductible or, or apply that to your deductible.

CHAIRPERSON RIVERA: So can you all speak to why hospital costs vary so much for the same procedures? For example, why one hospital system

charges $9000 for a standard colonoscopy, while the average of all the others is only $4000?

LESLIE MORAN: I cannot really speak to that. That's a, a question that we have as well.

CHAIRPERSON RIVERA: So how does...

DAVID RICH: Yeah, I can't necessarily speak to that specific example, but, you know, what hospitals, ah, have to do is negotiate with a variety of insurers. Um, some of the insurers, as I mentioned before are national in scope. Um, they don't have a whole lot of power when they're negotiating with some of these larger insurers. Um, some hospitals may have a lot more, um, enrollees for one insurer that use their hospital than another, in which case there might be a dynamic in the negotiation where both the, where the insurer feels like, ah, because their enrollees have shown a preference for that hospital, where they may negotiate a higher rate than they might with another. Um, one problem that we do have which I think was very inadequately discussed in the, um, New York State Health Foundation report is that a lot of our safety net hospitals in the Bronx, in Brooklyn, in Queens, ah, don't have as much in terms of

commercially insured patients and so therefore they don't have the ability to negotiate, um, very good rates with the, um, private insurers because the private insurers feel like they can pay them whatever they want to pay them, frankly. And so they tend to have lower rates than hospitals who have a higher, um, level of commercially insured, um, patients because the insurance companies feel like they need to compensate them in order to take care of the large number of [inaudible]. So that can vary. If you're a teaching hospital you have much higher costs than you do if you're a non-teaching hospital, um, for a whole variety of reasons, including you take the most complex cases the community hospitals will transfer to you, so you have the high-cost cases, a disproportionate number of the high-cost cases opposed to the low-cost cases. Um, and, and also we really can't ignore the fact that Medicare and Medicaid so underpay hospitals that they feel they need, if they can, to, ah, charge more to other payers, if they can negotiate those larger payments because the Medicaid program the State of New York covers 70% of the cost on average of the cost of a Medicaid patient being served by a hospital. So

there are a whole variety of different reasons. Like there might be variations, um, but those are some of them that I can identify.

CHAIRPERSON RIVERA: So how do you all analyze the study, you're gathering metrics about cost discrepancies between systems?

DAVID RICH: We don't. We're not really allowed to know all the different prices because of, um, antitrust requirements, so we really are not ones to analyze prices across different hospitals, but perhaps Leslie could answer the question.

LESLIE MORAN: We have the same, um, antitrust protections in place for our members as well, so we, we cannot gather, um, the negotiated, ah, you know, costs that individual plans have with their, with their hospitals that are in their network, so we don't have that type of, um, analytical ability.

CHAIRPERSON RIVERA: So what more can hospitals do to ensure hospital accessibility and affordability for patients?

DAVID RICH: Well, I think that there are a variety of things that they, um, currently do, um, and that they continue to do. Number one, they do

have, um, robust financial assistance policies, many of which go beyond the state requirements for financial assistance. Um, they also are, as I mentioned, providing the cost estimators so that we can understand the cost. They, unlike any other provider, not physician groups, not freestanding am-surg, not anyone else, take everybody who comes to their doors, so obviously they are the most accessible providers that there are out there, um, and so, you know, I think that, you know, the idea that they are completely inaccessible to, um, to New Yorkers I think is, is not the case. But I think, you know, look, there are lots of the community are trying to do to because as accessible as possible. Thank goodness New York now has a relatively low uninsured rate. Um, what they also try to do when people are, um, come in and are admitted to the hospital is they immediately try to, um, sign them up for whatever public health insurance they're available, is available to them and they're eligible for. So they sign them up right away for Medicaid, if they're an undocumented person they sign them up for emergency Medicaid. Um, they'll sign them up the essential plan to the extent they can, um, and a

whole variety of different ways. And we have always strongly supported, along with our partners 1199 SCIU all of the different public health insurance options that we work has taken and hopefully will continue to take on in the future to make sure that healthcare is accessible as possible to vulnerable New Yorkers.

CHAIRPERSON RIVERA: And you mentioned the, the federal rule and, you know, starting January 1 of this year the Federal Hospital Price Transparency Rule required hospitals to display files on their websites containing gross charges, ah, pair specific negotiated charges, discounted cash prices, and de-identified minimum and maximum negotiated charges. And so what percentage of your members are complying with this rule, and for those that are not complying what is the reason?

DAVID RICH: So I did mention this before. Um, I don't have a percentage. But all of them are complying with the standard, you know, the standard charges requirement, which, as I mentioned, has been in effect, ah, for a while because the ACA required that. Um, they are, um, all, all either, um, complying with the 300 shoppable services or the cost estimator, which there was a choice in the rule

to have the cost estimator, out-of-pocket cost estimator that I mentioned before, or a list of 300 shoppable, um, services that, um, and the negotiated rates. What they have been struggling with, very frankly, is the, um, the requirement that they put every single item in service and the negotiated rate with every single insurance company, um, on their website. That has been difficult to comply with. We have a number of hospital systems that have, but we have others who are still struggling with that, and frankly where our safety net hospitals are going to have the, the people power to actually comply with that kind of requirement when they are working as hard as they can just to keep their lights on is a really, an issue. I think they need some help. They need resources. We all know they need resources. But it is gonna be very difficult for them to come into compliance with, um, that kind of a rule that will require them to take people away from other, um, duties in order to go ahead and, um, comply with that rule.

CHAIRPERSON RIVERA: Well, as I mentioned in my opening statement, H&H is compliant, ah, friendly reminder. So what, what can the city do to

ensure better compliance from others with, with this rule and how, has this rule helped patients receive better care?

DAVID RICH: You know, I don't know. It depends on whether this rule really helps patients understand what they're looking at. I think have lists and lists and lists and lists and lists [inaudible] negotiated rates for each item in service is gonna be extremely overwhelming for a consumer, which is part of why the options given, um, for 300 shoppable services under the rule, or the out-of-pocket cost estimator, so I think, um, we will see if, if, um, consumers find the cost estimators to be helpful to them. As Leslie mentioned, insurers have those as well. Um, it really is the insurers who have a better sense of who is still enrolled in their insurance plan, what their deductibles are, how much of their deductible they've met. It's very difficult for a hospital to know that. In September, that, of course [inaudible] none of their deductible yet or all of it yet. Um, so in, in many ways I think the insurer really has much more of the information that, um, a consumer might need than a hospital might. Um, but it has been very difficult to comply with that

one piece, which is, um, every single negotiated rate for the thousands and thousands of items and services the hospitals provide.

CHAIRPERSON RIVERA: So let me ask you, Ms. Moran, how do insurers and other stakeholders determine the cost of the procedures they cover?

LESLIE MORAN: For the most part they are negotiated, um, with, with the hospitals, um, and it, it's, it's a regular. or a renegotiation process on a regular basis. But they are based also as, as David point out, there are some kind of guidelines, some, ah, the diagnostic-related groups. So you, you know what is kind of usual and customary, if you will. Um, but to, to David's point about the overwhelming amount of information for consumers, um, you know, everybody gets their insurance policy and it's, you know, a hundred pages long and most everybody sticks in a drawer or someplace, thinking I'll read if I need to, to see what's in there. Um, but some information is included in that. But what consumers really want is easy to understand, digestible information. And they mostly want to know how much is this going to cost me, um, and that's where the consumer cost estimators come into play.

It's where, um, health plans' customer service departments come into play because the consumer can always reach out and talk to someone at the plan and have someone help them walk through what the procedure is, what their deductible is, what the cost might be, um, at different facilities, again where can't help the consumer is by saying to them hospital A has, you know, a better quality rating, or hospital B has, you know, the same quality rating but a lower, um, charges a lower price for that procedure. So that's, you know, we think that's someplace where, um, we could use help from the policy makers in order to make it easier for consumers to get that type of information on, ah, quality and value at, at the different facilities that they might be considering.

CHAIRPERSON RIVERA: All right. So I, my last, I'll ask one more question and, and turn it over, um, to my cochair. I guess, Ms. Moran, in 2019, as I mentioned, more than 10% of adults have reported, ah, that, that, ah, they delayed or did not get care because of the cost. What, what is being done to address this?

LESLIE MORAN: Um, that's a, a very good question. Um, we work hard with patients and, and

consumers to try and make sure that they understand what, what their coverage is. Um, but again, as I said, for many, many people it's what is gonna to cost me and, and it's a conscious decision to take a, a policy that might have a higher deductible because the premium remains low, and you have someone who thinks I, you know, I'm never gonna meet that deductible because I'm healthy and nothing's, you know, I don't have any serious healthcare needs, and I just want to make sure I have coverage. And then they turn around and something happens and they're saddled with, um, they get sick, they get COVID, um, or anything else and they suddenly need to go to the doctor, but they're worried about meeting that deductible. Um, you can't unwind and go back and change the decision that was made at the front end to take that health plan. The only thing we can do is try and better educate consumers about the, the, ah, value of the products that they are buying and make them, you know, consider all the various scenarios that might come into play, um, so that they're aware of it. But ultimately it's a consumer decision.

CHAIRPERSON RIVERA: Well, um, I, I appreciate it. I, I, I thank you for being here. I

know that we'll certainly, we'll hear from my cochair now and there are people here to give their perspective and their story, so I do hope you'll, you'll stay the duration of the hearing to listen.

LESLIE MORAN: Certainly.

CHAIRPERSON RIVERA: Um, and with that I will turn it over to my cochair, ah, Mark Levine, for, for his questions. Thank you.

CHAIRPERSON LEVINE: Thank you so much, Chair Rivera and, ah, we appreciate both of, Mr. Rich and Ms. Moran, for being. I just want to start by, by speaking for myself and I think everyone who is testifying today, ah, there, there is no doubt at the, the depth of my admiration for healthcare workers, ah, something I and I think everyone else here speaking today has expressed, ah, quite passionately, ah, over the last year and a half and, and before. There's no contraindication between, um, uplifting our healthcare workers and their heroic efforts during the pandemic and wanting fair and transparent pricing in hospitals. Um, which also, ah, is a matter, ah, of great interest to workers, other essential workers. And in fact, ah, I think fairer, transparent pricing ultimately, ultimately

would be a win-win and would probably be good for the hospital sector as well. Um, ah, but getting on to questions, um, Mr. Rich, you, you, um, laid a lot of blame on pharmaceutical companies, medical device manufacturers, insurance companies. Ah, I'm not here to defend any of those players, believe me. But we have a situation where two hospitals who are buying the same pharmaceuticals and the same medical devices are charging, ah, totally different prices for exactly the same procedures, the same MRI of a lower limb, or the same colonoscopy, ah, the same bariatric surgery. Ah, prices can vary by thousands of dollars, ah, and they're facing the same constraints, all the constraints that you describe, and I'm not talking about a hospital in New York City versus a hospital in North Dakota. I'm talking about two hospitals that can be in the same borough, both in Manhattan, um, and I'm, I'm, I'm also not even comparing an academic medical center to a public hospital. Ah, I mean, this is the ultimate apple to apple comparison. You can look at two academic medical, ah, centers, ah, providing services, both in the borough of Manhattan, sometimes very close to each other. And the prices can be quite different.

And I, I've, I've tried to study this issue. I can't wrap my mind around how that's possible. So perhaps you can explain the differential in pricing where the only variable is which hospital system the patient is going to.

DAVID RICH: Sure, and I'm, I'm glad you asked this question because it gives me an opportunity to, um, to make a point that I think will be, um, made in a continuous manner later. We have one of the most competitive, if not the most competitive, hospital system in the country. We have six major hospital systems competing with each other. Um, H&H, we have Montefiore, we have Mount Sinai, we have NYU, we have Northwell, and we have NYP. So the idea that there is one dominant healthcare system that is able to just sort of, you know, be a monopoly is absolutely not the case. We also have smaller hospital systems. We also have a whole variety of independent hospitals. So, so the, the, ah, the accusation that is sometimes made that we have hospitals with so much market share, that don't have competition, um, they can do whatever they want, is just not the case here in New York City. Um, they have major, um, competitors and if prices vary, they

probably vary for a whole lot of different reasons. These are also prices, I should point out, and as, you know, as Leslie mentioned, um, there are negotiated rates with insurance companies. Who, by the way, are consolidating more and more, um, between United Health Care and Aetna and, um, and Empire, which is Anthem at the national level. So, you know, I can't totally give you all the reasons why there may be a hospital system that has higher prices for insurer, lower for others, um, because those all subject to the vagaries of negotiations between two parties. Um, but I do know that we have an extremely competitive hospital system. In places where they talked about mergers increasing prices are really places where there's one hospital system for the whole area, or maybe two, and there's very little, you know, there's very little the insurers can do about lowering prices. That's not true here in, in New York City. Um, people have a lot of choice and a lot of different hospitals that they can go to. Um, and so anyway, ah, that's, that's my answer, such as it is right now.

CHAIRPERSON RIVERA: Um, thank you. I want to acknowledge just, ah, for a moment that we've

been joined by two of our colleagues, ah, Council Member and Dr. Mathieu Eugene, and Council Member Ampry-Samuel. Um, and you said that there are six, ah, you pointed out that there are six, um, major hospital systems in the city, but, ah, boy, that number is way down. Ah, we have seen a pretty remarkable wave of consolidations and mergers and, and even some closures over the past, ah, decade or so. Ah, I mean, dozens of these types of, of transactions. And [inaudible] basic rules of the marketplace is when you have fewer, ah, entities competing, ah, it gives them the chance to raise prices. Ah, why, why doesn't that, that rule apply here when the number of hospitals competing in the marketplace has gone down from scores to now, ah, only six.

DAVID RICH: Well, it's not only 'cause there are independent hospitals and there's also, you know, ah, [inaudible], Hospital for Special Surgery, with also a lot of independent hospitals in the city. But, you know, they're negotiating. They all want, you know, as much market share as they can get, and people can vote with their feet. People can decide. They'll go to one hospitals rather than another, and

the more transparent these places become more people will be able to do that, and the more that, you know, again, I think it's the insurance companies that are best equipped to provide these cost estimators 'cause they know what, how much of the deductible someone's used or what part of, you know, if you have an HSA or [inaudible]. Um, I think over time, but this, this is an incredibly, um, an incredibly dynamic and competitive marketplace. I should also say that the state has encouraged large systems to take on smaller hospitals that are having difficulty surviving on their own. Um, we've seen that in hospital systems, um, helping out and taking, and are taking over hospitals in Brooklyn, in Queens, in the Bronx, in southern Westchester, Montefiore with Mount Vernon, and, and, ah, New Rochelle Hospital and some others. So that's been, that's been a policy of the state to try and help these smaller hospitals that are more financially challenged to become paired with a larger system so they can benefit from some of the, um, scaling opportunities that they have being part of a larger system.

CHAIRPERSON LEVINE: By, by definition with pricing, ah, this inconsistent there are some

sort of breakdown in the normal kind of competition that, ah, would generally flatten prices in a marketplace. Ah, and I, I cited, ah, a, a few procedures earlier, ah, that, that are, are [inaudible] researchers have determined, ah, wildly divergent pricings. Um, just how much variation is there? Ah, how much variation is there in the cost of a colonoscopy, ah, between the highest and lowest prices providers in New York City?

DAVID RICH: That I do not know because we are, again, we're not allowed to collect pricing information because of antitrust issues amongst our members. Um, it's possible that Leslie representing the payers would have a better sense of that. I, that information I do not have.

CHAIRPERSON LEVINE: Well, just based on what advocates have been able to piece together from public sources, ah, it's clear that those prices vary a lot, that, ah, sometimes it can be, it can cost more than double, ah, in some extreme cases even, ah, a higher markup than that, and, and these are very expensive procedures. So you're talking about thousands of dollars potentially, um, for exactly the same procedure and I just want to reiterate 'cause

it's such a key point, these are hospitals which are buying from the same drug companies, the same medical device companies, they're working in the same, ah, ah, employment environment, ah, and so, ah, it, it just, it, it boggles the mind that there can be such variation in price, ah, to that design. Ah, I, I, I do want to talk about the federal, ah, hospital transparency rules, which you, you have been very careful, ah, to, ah, continually describe as Trump administration rules, ah, ah, of course knowing that he's not a popular guy around here. I, I want to clarify that, um, this kind of federal, ah, requirement for hospital price transparency has been long sought after by patient advocates for years. And, ah, somewhat weirdly the Trump administration latched onto this. Ah, maybe it's because Donald Trump doesn't like paying bills. I don't know. And like most of what Donald Trump, let me just rephrase that. Like everything that Donald Trump touches, he made something of a mess of this. I certainly acknowledge that. But needless to say, there's additional information which now, um, about pricing which now, ah, the, the law requires, um, ah, come out in a transparent way, and that does at least

offer some new tools for consumers and advocates to understand the scale of the problem that we're describing, that you just conceded, ah, it's difficult to get a grip on because of, of the opaque nature of, of, of this, ah, industry. Um, and, ah, it is, it is currently the law that all hospitals are required to comply with. Um, forgive me if you said this earlier, um, Chair Rivera may have asked this, but what percent of your members have now, ah, complied with making, ah, the required pricing transparency public?

DAVID RICH: I do not know the percentage, um, Mr. Chairman. Um, I know that some have. I know that some have not. Um, it also depends on which parts of the regulation, um, are at issue. The standard charges, um, they have all had on their websites for a number of years, because that was not a new requirement, although it was repeated in the, in the, um, in the new rules. Um, the, they are all providing cost estimators, which was allowed in lieu of the 300 shoppable charges, um, or negotiated rates, um, that were, um, that were provided for in the rule. But, again, the, the piece they've had the most difficult time from a, ah,

burdensome and [inaudible] our perspective is the missing out of just thousands and thousands of items and services with different negotiated rates, within different insurance companies, different, um, products that are, ah, negotiated by insurance companies. Insurance companies have Medicare products, Medicaid products, um, HMOs, PPOs, other types of products, all of which often have different negotiated rates associated with them. And then multiply that by a whole number of insurers and thousands and thousands and thousands of items and services that need to be listed. Um, again, I question the utility of that for a specific consumer because [inaudible] listed on a website and spreadsheets that are, will go, necessarily go on and on and on and on. Um, but I think the cost estimators, which is sort of the hospitals have rooted for this time, because we think this is probably the most consumer-friendly piece of this, and that consumer understandable piece of this as well as what the insurers are doing in terms of their process [inaudible] what would be the things that are going to be most helpful for consumers.

LESLIE MORAN: I would add...

CHAIRPERSON RIVERA: Go ahead, Leslie, please.

LESLIE MORAN: Um, I was just gonna come in behind David with I think he has highlighted some of the difficulty, um, you know, of consumers getting some information, I mean it, not to invoke the former president's name again, but the one thing I would say we could all agree with was his statement about who knew that health care was so complicated. So consumers don't shop for health care the same way that they shop for other things. I mean, consumers have long used *Consumer Reports* when they're buying a, a washing machine or something like that. Um, I, I use the example oftentimes of, you know, I have, I have two dogs. When I go to the vet, um, I do get an estimate of what the procedures, what the charges are gonna be based on what procedures are going to be provided. So, you know, I have an estimate and we can discuss that before we go forward with it. Consumers don't shop for their health care in that way, um, in part because health care is a much more, um, if you will, emotional purchase, um, you, you actually hope you're not going to be using health care, catastrophic health care, um, much, but you

want to make sure that it's there. Um, but it's also, you know, people don't pick their doctors. They pick their doctors not based on what their charges are gonna be, but by whom their neighbors have recommended or who they have a relationship with. So it's a very personal, um, service, if you will. So, and, and I think it can be overwhelming to consumers to give an overload of information. On the flip, I would point to some of progress that we've made. I mean, if you look at, um, the New York State of Health, you are able to go into the New York State of Health, the marketplace, and plug in your parameters for what you want and up will pop a number of choices of health plans for you to choose from and you'll get the very basics on what your premium would be, what your deductible would be. Um, you can then drill down and find out what the networks are of, you can make sure that a doctor you want to see is within that provider network, a hospital in your community is in the, in the provider network. So there is more information as you drill down. But many consumers get overwhelmed as they go down page after page after page of this information. So I would just argue that there are ways we can try and simplify it and make it

easier for, for consumers. But at the same time you want to make sure they have access to that wealth of, of information that truly is necessary for them to make the best decisions, best and most informed decisions for what's best for their healthcare needs.

CHAIRPERSON LEVINE: It's true that if I have a medical emergency of some sort I'm not gonna pause and, and navigate to the navigate to the federal website to review pricing.

LESLIE MORAN: You're gonna go and get it taken care of.

CHAIRPERSON LEVINE: Of course. But all the more reason to ensure we have fair pricing in those circumstances because the patient isn't gonna be able to, to shop around and that, ah, without constraints, that could be exploited and...

LESLIE MORAN: Right, and that's why, that's why we've taken steps in New York, um, through, you know, landmark legislation in New York to protect consumers from...

CHAIRPERSON LEVINE: Surprise medical bills.

LESLIE MORAN: Um, surprise billing, and, and...

CHAIRPERSON LEVINE: But, but even, but, but even, ah, in cases where it's not an emergency, where it's a scheduled procedure, ah, and so I have time to, ah, think about where I want it done, ah, it's, it, you, you need a master's in, ah, and it's, there's just no easy way, even if you have time to sit and review where you want to get the procedure done to easily compare prices and, you know, the, the truth is that the, the federal transparency rules, um, really, ah, are not perfect and, ah, I think advocates have made that point, um, ah, point quite, ah, openly. But, you know, the, the hospitals could, could solve this on their own. They could do better. Ah, they could take the federal rules as a baseline and create really clear, transparent, consumer-friendly, apples to apples communication on this and the fact that that hasn't happened, ah, um, makes, makes me wonder how committed, ah, the hospitals are to solving this problem. What, what, what, what do you say on that, ah, Mr. Rich?

DAVID RICH: I think they have. As I mentioned, they have put into effect the cost estimators options a part of the rule. They made a priority of doing that, because that is the, the, the

one piece we think of the rule that is going to be most helpful to consumers. They want to, you know, go to a cost estimator, figure out what their out-of-pocket costs would be. I mean, and also, I mean, one thing that I think Leslie was getting at, too, is I know when I have a procedure and, you know, I rely on my doctor to refer me to a surgeon who uses a specific hospital, um, and that's pretty much how I make my decisions, because I trust my doctor, you know, and where he or she is going to, ah, send me. So, you know, the, the shopping around doesn't happen quite as much as people might think it would because of that dynamic. But, again, they are committed to this. They've done the cost estimators. Again, I think they've made a priority of what they thought consumers would find the most helpful as opposed to the Excel spreadsheet that goes on for thousands and thousands of pages. And so I think, ah, I think they're very committed to it and they've done. And, by the way, um, the speaker before us said a 300 million dollar fine. Those fines have now been up to, um, 2 million dollars depending on the size of the institution. So, you know, even just ignoring this, they write more laws or regulations, they're

trying really hard to comply with what is an extremely [inaudible] rule.

CHAIRPERSON LEVINE: Um, I did want to ask a couple questions, ah, to Ms. Moran. Um, ah, Mr., Mr. Rich had stated, ah, and it's been widely reported that, ah, the pandemic has been very profitable for, ah, the insurance industry, particularly for large insurance providers, which, which are covering the great majority of New Yorkers. Ah, how can you explain, ah, what, what Mr. Rich called multi-billion-dollar profits, um, in the face of, of what appears to be, ah, what clearly is over-charging, ah, of patients.

LESLIE MORAN: Well, um, first of all, I would go back to my comments that in New York and even and, and nationally there are requirements set in statute for what percentage, what, how much of each, um, health insurance premium dollar must go to pay for medical care. In New York State it's 82 cents of every dollar, or 85 cents in the small group market. Um, nationally it's 85 cents of every dollar. So those "profits" that, that you're talking about some insurers making are largely from investments and dividends and things like that.

They're not coming out of the premium dollar. That premium dollar has to be dedicated to, um, health care. Um, and when you look at the actual profit margins, of the rate of return for health insurers nationally, um, and those in New York State, you know, those making a, a profit margin of 4% is rare, so they're on par with many hospitals, and what hospitals are making, and, and many of our plans are making, ah, have a return of less than that. So I, I think talking about the two things, ah, together is, is not accurate because the premium dollar goes to, to health care. Profits come from other investments and other, um, things within the insurance model. I would say that during the pandemic, um, health plans were not making a lot of money. They were actually, ah, health plans were asked and responded, um, to providing healthcare services for COVID treatments, for testing, for vaccines, all without any cost sharing. Many of those, ah, emergency regulations are still in place. So plans were paying for those costs without anything coming out of the consumers' pocket, which we agreed was the right thing to do. In addition to that, health plans also, um, extended grace periods. So for individuals who couldn't pay

their premium or, or businesses that couldn't pay their premium they had extended grace periods so they could maintain their coverage, and in fact the New York State of Health has put out reports that show that in New York people didn't lose their coverage during the pandemic largely because of the efforts of health plans working in cooperation with the state to make sure the coverage stayed intact and that people could get access, we felt it was vitally important that people have uninterrupted to care during the pandemic and that's ongoing. Um, and then lastly I would point out that those costs that plans have absorbed in terms of delayed premium payments, in terms of paying for, um, hospital and, and doctor services and vaccines and, um, testing and treatment for COVID, um, those are costs the plans have to absorb and will be seen probably in losses that we will start realizing this year and next year. So we haven't really seen the impact of the COVID, um, pandemic on health plans. There have been some national estimates that say that the impact on health plans, what they've absorbed will be in the 60 billion dollar range or higher. Those are costs that

plans have absorbed that we're gonna see the impact of down the road.

CHAIRPERSON LEVINE: Well, the, the, the level of transparency on this calculation of 82% of premiums going into health care might even be lower than the level of transparency on hospital pricing. We can probably do a whole hearing on that.

LESLIE MORAN: Well, um, actually, they, they have, plans have to, health plans are the only part of the health...

CHAIRPERSON LEVINE: Just let me, just let me finish my point....

LESLIE MORAN: Sorry.

CHAIRPERSON LEVINE: ...'cause we have a lot of people waiting, waiting to speak. But the truth is that I've, I've heard the analogy that if someone tells you, you can only eat 82% of a bowl of ice cream you're just gonna ask for a bigger bowl. So the, prices, prices just continue to go up. But, but on the top of profits I, I just did want to ask Mr. Rich, hospitals in New York State are, are nonprofits but still the term profit is often used in that context and there was a report on Axios that identified a 12% profit margin at Northwell, ah, and

so how, you know, how should the public be comfortable with that when the cost for some procedures from commercial insurance is triple what it is for Medicaid, ah, at that hospital network.

DAVID RICH: Well, I'm not familiar with that statistic and I know that we did a survey of our members, including Northwell, um, just recently to figure out where their financials are post pandemic. Um, overall the hospitals had -3% margins in 2020, um, even with the federal assistance that came in, which, by the way, many of our hospitals would not have survived without that federal assistance. Um, so, ah, that does fit with the statistics that you just gave, and also, um, in the first six months of this year, um, overall our hospitals made about a 0.5% margin, barely breaking even. So I, I can't speak to the, the statistics you got from Axios, but that does not fit at all with our understanding of what our hospitals' financials are at this point. I mean, the amount they had to spend last year and continue to spend, because the pandemic is not over yet, even though everyone wants to act like it is and hospitals are no longer dealing with [inaudible], but, you know, they still have extremely high costs

and they are still struggling financially because of the pandemic.

CHAIRPERSON LEVINE: Um, ah, if, if, if you follow me on Twitter, Mr. Rich, you know I'm not acting like the pandemic is over. Ah, and, ah, I, I know you're not feeling it in the hospitals. Ah, I, I do, ah, just, ah, because we have a number of our colleagues who want to, um, ask questions, I just had one final question for, for Ms. Moran. Um, I don't think the public understands that, um, many people, ah, get their health insurance through a self-insured plan, often through a labor union. And I wonder if you could explain how that's different and what portion of, of, um, the public is actually getting their insurance from, from self-insured plans?

LESLIE MORAN: Certainly. So self-insured, um, fully insured means that the health plan oversees the, um, payment of claims as well as delivery of the healthcare services through its network of providers. Self-insured means usually a large employer, um, does all the, the, they control the money part of the, ah, the healthcare, you know, what they're going to spend on health care. They, they develop a budget annually for what they will

spend on healthcare, um, and then they will work with the health plan and use the health plan's network and, and very often use the, the health plan to process its claims. But some of the self-insured plans actually do their claims processing themselves if they're large enough. Um, self-insured plans are exempt from state laws so they can design their own benefit plans and, and do their own negotiation on premiums and, and negotiations with hospital costs, etcetera, as 32BJ, the 32BJ Fund does, and other, um, public employers do. Um, and to answer your question about the percentage of New Yorkers that are self-insured, ah, I believe the statistics when we last looked at them was it's about 53% of every person who has health insurance in New York State is in a self-insured plan. So they are in a program that is not covered by state or city regulations.

CHAIRPERSON LEVINE: Right, and it just, it emphasizes the point that, um, these pricing problems directly impact workers who ultimately are, are bearing the cost, um, because, ah, they have to put their negotiating capital, ah, into, ah, bearing higher and higher hospital costs as opposed to wages for workers who very much need it. So, um, ah, I, I

do want to pass it on to our colleagues so I, I thank you both, ah, Mr. Rich and Ms. Moran, um, and I will pass it back I guess to Ann to, to cue us for our next speaker. Thank you.

MODERATOR: Yeah, thank you, Chairs. Um, I'm now going to turn it over to council members, other council members, for their question. As a reminder, if council members have questions for a panelist you should use the raise hand function in Zoom at this time. So, um, I will first call on Council Member Eugene, followed by Council Member Holden.

SERGEANT AT ARMS: Time starts now.

MODERATOR: So, um, Council Member Eugene, um, may be having some technical difficulties. So instead I will turn it to Council Member Holden if Council Member Holden is ready.

SERGEANT AT ARMS: Time starts now.

COUNCIL MEMBER HOLDEN: Thank you, both. Ah, thank you all. Thank you, Chairs, and thank you for, ah, both of the great testimony, um, and I just want to, ah, touch upon David Rich's comments, ah, early, you know, in the, ah, in the testimony. Um, by the way, Mr. Rich, I agree with you. The

Assemblywoman's unfortunate comment that hospitals allegedly saves lives was hurtful and disrespectful to the thousands of dedicated men and women who serve every day and night in our hospitals, with so many stressful situations. They do save lives. There's no doubt about that. So I agree with you, David, um, and I, and I understand your passion on that. So that comment was out of line. Um, um, I think we all understand that dealing with insurance companies can be frustrating and puzzling for everyone, I mean, even for hospitals and, and certainly for patients. Um, and I think we can all agree an overhaul of the process needs to be examined. I know you think we've been trying that for a long time. But let me ask about the hospitals' internal operations regarding trying to cut costs without compromising quality, the quality of the health care. Ah, for instance, I'll give you a couple of examples. Um, I had a recent hospital stay, along with my mom. My mom is 97. She had a hospital stay, and I noticed something that was very curious in both stays that I didn't notice when I was in a hospital very, very long ago, years ago, like let's say 20 years ago. I, we didn't get, I kind of felt there was a duplication of services, Mr.

Rich, you know, um, that appeared to me that either the hospital or the doctors that were coming were trying to pad the bill, because they would ask, I would get, you know, doctors coming in every few hours, asking the same questions that I had just answered, and it was like, there seemed to be no point, um, in the visit, that, 'cause they were asking the same questions, doing the same things, and coming up with the same, you know, solutions. There was like four different doctors on within, like let's say a three- or four-hour period, and then they were, obviously they were charging for their visit. So it seemed to me that maybe that's a little bit, ah, you know, of padding. Is that, does the hospitals, do the hospitals really, ah, and 'cause I mentioned this, my son works at a hospital and I mentioned this to him and I said, he goes oh, yeah, we need to examine our procedures, um, and I jus thought that, um, that should be a focus where we could try to save, we're not compromising health care. We could try to see where there's a duplication, where there's waste. Does, does, do the hospitals do that.

DAVID RICH: Yes, and first of all thank you so much for your comments, ah, Council Member

Holden. I really appreciate them. Um, they do, and I, you know, I can't speak to exactly what happened, um, in your case. Um, there are different situations where they may be some duplication. For instance, in teaching hospitals, for instance, there may be situations where, um, an attending physician is attending [inaudible] the resident will also come and check in on a patient and, um, check in on how it's going. Um, there may be different specialists that are part of the case may have slightly different reasons [inaudible] not a patient. Um, you know, again, I can't speak to your exact, um, your exact situation and I would hope that they were not just totally duplicative, um, visits and I, I know that the hospitals certainly do everything they can to try and make sure there's not duplication. It's not in their interest for someone to be in the hospital longer than they need to be, partly because, as I mentioned before, they, they're paid sort of one amount, which is that DRG I was talking about before, no matter how long the patient stays. So, ah, duplication is not something that certainly, um, helps the hospital financially, um, you know, and I would hope that it would be physicians just charging

again for something that someone else did before. But certainly efficiency, especially given, um, you know, the difficulty with low Medicare and Medicaid reimbursement rates, um, and, ah, and other, you know, difficulties in terms of downward, ah, downward pressure on private payer reimbursement rates. Hospitals are certainly doing everything they can to become more efficient. Which is not to say there's not more that they could do.

CHAIRPERSON RIVERA: Yeah, I [inaudible].

DAVID RICH: [inaudible].

COUNCIL MEMBER HOLDEN: I think if a hospital was made to look at trying to keep costs down, that's the goal, right, and I know they probably do it, but in this case I had, again, four different doctors with both my mother and me that they weren't communicating with each other and they were asking us the same questions and taking up the time and saying, you know, it's just like I could see a tremendous waste her. If one doctor did it and they all communicated...

SERGEANT AT ARMS: Time expired.

COUNCIL MEMBER HOLDEN: ...[inaudible] the visit. So, just, that was a small example but I, I

could, I could see that if we really made it an effort to cut costs we could probably do that within the hospitals. But I, I agree. We shouldn't blame the hospitals for the, you know, rising costs of health care. I think it's, um, it's a number of reasons. But, again, I want to thank you, you all for your testimony. I think, ah, we really have to get busy and, and try, try to cut costs, but without, you know, like I said, compromising health care. Thank you. Thank you, Mr. Rich.

DAVID RICH: Thank you, Member.

MODERATOR: Thank you, Council Member Holden. We will now turn to Council Member Eugene.

SERGEANT AT ARMS: Time starts now.

UNIDENTIFIED: Council Member, you are on mute.

COUNCIL MEMBER EUGENE: Can you hear me now?

UNIDENTIFIED: Yes.

COUNCIL MEMBER EUGENE: I think you must. Let me, ah, thank and commend, ah, Mr. Chair. Thank you so very much. And I want to thank also all the speakers for their testimonies, a lot of information. That's very wonderful. One of the things that I

should, ah, mention, comment on, and we all agree that the hospitals they are doing a wonderful job, the doctors, the nurses, the [inaudible] they're doing a wonderful job saving people all the time, in good time and bad time. And, ah, ah, what I want to, ah, comment on and also ask a question about is about the system used for the, you know, for the, ah, to provide services, to provide medical services. We know that medical services is, is a, is a obligation of all of us, you know, hospitals, society, government, and government should [inaudible] funded to everybody, everybody. That everybody can use the system without having the consequences of not having, not, ah, receiving, you know, the help that they are looking for, and also a system that won't create, ah, challenges for them and putting their, their financial situation in jeopardies and even their families. So, ah, we know that everything now should go through computers. We're using computers and we're using technology for everything. But there is, there is a large number of people in our society in New York City, they are not completely literate. They're not in the technology that we are using. And those people, they're entitled to the same services

that we as a society, as government, as country we should provide. And, ah, many time, many of them get to the hospital. They don't have a clue about the insurance, between the insurance, this insurance and that insurance. They don't have a clue about the cost of the procedures. They just go through and after that they end up [inaudible] to, ah, ah, situation. Their credit, ah, is messed up and, and all the other consequences. My question is, ah, ah, what can we do, I think that something, before I ask the question, I think that we should do something. We should work together, hospital, insurance companies, government, to make sure that we provide informations and knowledge, education, to those people who are not able, capable of using the system that we're using, computers and [inaudible] what is in place and who can implement, I don't say recreate, but I know that we can do that. What is in place right now to make sure that those people [inaudible] computers and I, I got to say also we know that New York City is a city of immigrants. There are many people, they're immigrants, you know, it's difficult for them to navigate through the system and navigate through the medical system is another big challenge

for them. So what is in place we can implement to ensure that everybody can get access to the same quality of health care that we [inaudible]. We are [inaudible] state-of-the-art quality health care, I know that. But what can we do to make sure we did, we eliminate the health care, ah, ah, inequity, the disparity that exists in health, using [inaudible] other people, mentoring them, educating them, creating their promotion, what we can do if it doesn't exist already?

DAVID RICH: That's an excellent question, ah, Council Member Eugene. And I think, you know, one of the things that a number of hospitals, ah, did and started a while ago, but also picked up during the time when the state had [inaudible] which you might be familiar with, um, which really focused on community care, and really focused on trying to have community health workers, um, that would go into communities and discuss in a culturally competent that, you know, people who actually can speak the languages that need to be spoken in these communities and to try to educate people about their health insurance options, but also their healthcare options. Um, we've done a lot of

this with 1199 SCIU with the healthcare education project. But certainly it's something that really needs to be focused on. I think the community health worker model is one that is extremely in communities like the ones you're talking about, where people don't have computers, where they might not even have, you know, broadband that works very well, even if they do have computers, um, who really need to be met where they are...

SERGEANT AT ARMS: Time expired.

DAVID RICH: ...[inaudible] and so I think that that is one of the models that I think the city has been looking at before, the state has been looking at. Some hospitals have funded through, um, state funding and federal funding. But I think that's a model that should be, um, looked at, um, much more carefully and supported over time because otherwise, you're right, disparities won't be solved if we don't really reach these people where they live.

COUNCIL MEMBER EUGENE: With your permission, Mr. Chair, this is my last question. Ah, you say that you have been, the system have been looking into those, ah, possibilities. But I see

that a lot of effort, a lot of effort, ah, of investment have been made in technology, in all [inaudible] technology. Really that's remarkable the effort that has been made, you know, to make sure that all the hospital, all the system use the technology. But I would appreciate if we can make the effort also to implement, to invest in education of the people. You mentioned the union, 1199 [inaudible] we can use those union because they are powerful, they got the [inaudible], and also other organizations to reach out to the communities, to reach out with those people because health, you know that there's nothing as priceless, there's nothing more important than health of people. So we have to make sure we establish a system where everybody can have the, the, the same access to the quality of, ah, health that we are providing. And, again, thank you so very much for your testimony. And, Mr. Chair, thank you so very much. I don't know if you want to comment on my last, ah, you know, statement. Hello?

MODERATOR: Thank you, thank you, Council Member Eugene. Um, so I will now again invite other council members to raise their hands if they have a

question. Um, seeing none, I will now turn it over to Chair Rivera to close out the panel.

CHAIRPERSON RIVERA: Thank you so much, ah, for your testimony and for being here to answer our questions. I'm sure this conversation will continue. If there is any follow up we will be sure to contact the both of you. Thank you for giving your time.

MODERATOR: Thank you. Thank you, Chair Rivera. So we will now to turn our next panel to testify. Um, I would like to invite Senator Andrew Gounardes to testify. Um, so, Senator, you may begin when ready.

SENATOR GOUNARDES: Great. Thank you very much to Chairman, ah, Levine and Councilwoman Rivera. Thank you for inviting me. I'm sorry I missed my call time earlier. Ah, good morning, everyone. I really appreciate everyone's attention to this incredibly important issue, ah, and I, and I do think it's important to start out by saying that the topic that we're talking about today is not mean to be, by any means, an attack on healthcare workers, doctors, nurses, healthcare staff, ah, or to diminish or belittle the work that they've done, not just over

the last 18 months, but the role that they play in our society. Ah, I think that's an incredibly important thing that we should just make clear up front. Ah, and, you know, they pursue a profession because it, it, it's personal to them and they're trying to provide, ah, for the well-being and health of their patients. Ah, and what we're trying to talk about today is really about how do we ensure quality and affordable health care. There's a lot of conversation about the rise in hospitals prices, about what, you know, how, how some of the factors, ah, ah, led to where we are today, the reimbursement rates from Medicaid, which I think everyone agrees are just fundamentally flawed, which is why many of our smaller hospitals have gone under. Even Medicare, which only accounts for 80% to 85% of reimbursement costs here in New York, um, and, and that should be looked at as well. But what we're, what we're really driving at is the other extreme of that part of the spectrum is a system in which hospitals are able to charge more than 350% over the standard reimbursement rate, ah, for basic procedures. We can all agree that 85% doesn't cover everyone's costs and we have to figure out an answer

for that. But the answer cannot be we're gonna more than triple what the cost is in order to make up for that difference. That system is just unsustainable and that system leads to a situation where working-class New Yorkers, whether they, ah, work for the public sector, work for the private sector, individuals who just need access to quality affordable healthcare regardless of where it is are simply unable to afford it any longer. Ah, that is really what this entire conversation is about and there is no one symptom to that problem, but a big part of this conversation and a big part of this problem we've been able to identify has been the way that our large hospital networks have been able to leverage their own market power and their size to dictate the terms in many ways, ah, that patients have to pay. Because they negotiate with their insurance companies and there's multiple plans and we all, we heard all of that, but at the end of the day when those costs get driven up to 350% what the standard reimbursement rate is, it's not the insurance company paying that, it's the patient. That's money coming out of a patient's paycheck. That's money coming out of someone's pocket. And

without being able to explain with a straight face as to why those costs are so egregiously high, what we are doing is subsidizing these large hospital networks that are overcharging our working-class New Yorkers, and we're doing so on the backs of people who can least afford it. That is why one of many topics of conversation that have to be looked at in this conversation around providing affordable and quality health care has to be the contracting practices that are used by hospitals in their negotiations with insurance companies that set the terms of payment out of reach for everyday New Yorkers. That is the purpose of the legislation that I have sponsored with my colleague, Assemblywoman Catalina Cruz, who I know spoke earlier, and we are trying to say that you cannot use anti-competitive practices. You cannot try to leverage your size and your power to dictate the terms and the payment that you're gonna receive without transparency, without accountability, and without any type of justification. That is the whole purpose of this legislation, and at the end of the day the people that we're fighting for is we are fighting for every single person in this state who needs to go to a

hospital to get health care, their healthcare needs met, whether that is a complicated process or a simple process or anything in between, what we are talking about is making sure that we don't send people into financial ruin because they are being expected to pay 350% more than what the average payment is for the same exact treatment at the hospital down the block. Ah, you know, some discussion was made earlier about how our hospital system here is already very competitive, and I think the point was made in response to that that people don't shop around for their health care they way they do for their car or for their house. They go where their doctor is. They go with wherever they know to go, wherever their friend tells them, wherever their family tells them. They don't have, the average patient does not have the ability to price shop to see where they should go get their colonoscopy, where they should go get their annual physical, where they should go for their x-ray. It's just not the way that people pursue or engage with the healthcare marketplace. So the, the analogy saying that this is already an over-regulated and over-competitive market just doesn't apply I think in the everyday lived

experiences of New Yorkers who are trying, again, just to get access to quality and affordable health care. So I really want to thank the council for shining a light on this issue today, for helping to tease out some of the nuances and some of the complexities and, and technical issues surrounding hospital billing practices. I think it's an important topic that needs to be continue to discuss, ah, and we will certainly take whatever feedback we're able to learn from today's hearing and use that, ah, in the upcoming legislative session up in Albany, both myself and my cosponsor in the Assembly, Catalina Cruz, ah, and, and make sure that we, we find a way to solve this part of the larger healthcare problem in our country. Thank you.

MODERATOR: Thank you so much, Senator. I'm now gonna turn it to the chairs. Chair Levine?

CHAIRPERSON LEVINE: Well, just briefly, I want to thank you, Senator Gounardes and, ah, Assembly Member Cruz, for speaking today, for leading on this. The problem is so big, it's so complicated. We need action at all levels of government. We need federal, state, and local action and, um, really happy to be partnering with, with you and Assembly

Member Cruz, and appreciate you both appearing today. Thank you so much.

SENATOR GOUNARDES: Thank you.

CHAIRPERSON RIVERA: I just wanted to also thank the senator for his leadership and we absolutely agree with you and are thankful to all of healthcare workers, executives, administrative staff, and, and so thank you for what you are doing in Albany.

SENATOR GOUNARDES: Thank you all.

MODERATOR: Thank you, Senator, and thank you, Chairs. We will now turn to our next panel. So I would like to welcome Kyle Bragg to testify. Following Kyle Bragg, we will hear from Cora Opsahl, Geofrey Sorkin, Rene Casiano, and Jimmy Brennan. Um, Kyle Bragg, you may begin when ready and once the sergeant cues you.

KYLE BRAGG: Thank you. Good morning to our cochairs, ah, ah, Councilwoman Carlina Rivera and, ah, Councilman Mark Levine. I want to thank, ah, the cosponsors of HEAL, ah, Assemblywoman Catalina Cruz, and, ah, Senator, ah, Andrew Gounardes, ah, for their work on this very important matter. Like Senator, ah, Gounardes, I want to also

open up by saying that, ah, be very clear that our dispute despite if you have it, ah, it's not with our brothers and sisters of 1199, DC37, NYSNA, the interns and residents, or all the other valued healthcare professionals and workers who provide, you know, ah, heroic service every day during the course of this pandemic and long before this pandemic. Be very clear that our issue with those who, who are responsible for setting pricing for procedures that are grossly varied across hospital systems. So good morning. My name is Kyle Bragg and I'm the president of SCIU 32BJ and as you know 32BJ is [inaudible] is the largest property service workers union in the United States, representing over 90,000 hard-working New Yorkers who work as cleaners, property maintenance workers, doormen, security officers, window cleaners, building engineers, the school and food service workers. Our members keep New York running and through the pandemic many of us have continued to show up every day to ensure that our city could function. In doing so, we've lost over 150 of our members, good souls who dedicated themselves as essential workers in the service of this city. At the heart of our union's work has been

winning the [inaudible], maintaining high-quality healthcare benefits for members and the COVID-19 pandemic has only underscored how vital these benefits are for our workers and their families. These benefits include premium-free family coverage, low co-pays, and a network of thousands of doctors that have real life-changing impacts on the quality of life of our members. Unfortunately, these benefits are jeopardized by the skyrocketing New York hospital costs. Several years ago our health fund in our union began looking at this issue, because of the health fund and many union health funds are self-insured. We pay all our members' bills for care, including the ever-rising hospital costs. Our fund has no profits or shareholders. There is no other interest other than providing workers with the highest-quality health care that they can afford. Empire Blue Cross, ah, Blue Shield administers the 32BJ health fund's network, authorize, ah, medical care, and pays claims using members' money. The funds, ah, pay Empire a flat administrative fee for their services. But the funds pay all medical claims. Every dollar spent on high-priced health care is a dollar that can be used to make other kinds

of quality and formal care available to the fund's participants. It offers much-needed wage increases and other benefits. Our health fund has analyzed our payment data and what we found is truly shocking. To begin with, we found that the five major private hospital systems in New York City - New York Presbyterian, Montefiore...

SERGEANT AT ARMS: Time expired.

KYLE BRAGG: NY Langone, Northwell, and Mount Sinai are charging our fund an average of 316% of what these same hospitals charge Medicare for the exact same procedures. This cost the fund to our members hundreds of millions of dollars over the past decade. In fact, our healthcare costs had simply risen at the same rate as inflation over the past decade our members could have received nearly $5000 more in their pockets as wages this year without costing our employees a cent more than the current total compensation. For our hard-working members trying to raise families in an expensive city, this would make a world of difference. Second, we have found real extreme differences in what our health fund pays for the same care at different, at different hospitals. The significant disparity in

price for the same care at different hospitals lacks rational justification. And we're not talking about ground-breaking new procedures. For example, our health fund paid an average of $83,000 for hip replacement at New York Presbyterian, but an average of $58,000 in other New York hospitals. Millions of dollars are being lost when hospitals overcharge us for care, and it has to stop. Before I go on, I want to make a few things clear. It's very important to understand, as I said, this [inaudible] hard-working doctors and nurses and medical staff. Second, it's crucial that we understand that price and quality are not the same. Our priority is always to maintain high-quality health care for our members, but there's no clear link between hospital costs and hospital quality. In fact, many low-cost hospitals have high-quality patient outcomes. Finally, I want to say that this is not just an issue for 32BJ members. This is an issue for all New Yorkers. The cost of health care rises for everyone. And whether you pay for your health care directly, through an employer plan, or are a member of a union, the cost is affecting you. And that's why we have [inaudible] coalition of affordable hospitals, including many

other unions, healthcare advocacy, and community-based and faith-based organizations. We also believe that it is impacting our city. New York City government is the largest purchaser of health care in the city, covering many times the number of lives that our fund does. And there is no reason to believe that this city is getting better deals than our fund is. We hope that we can hear from the administration soon about the city's hospital spend looks like, but it's simply, ah, exploring from our own fund, ah, and assumes that the city spends the same percentage of its healthcare expenses on hospital costs and would achieve the same savings as our fund would if we would charge Medicare rates. We estimate that the city may be losing over 2 billion to hospital overpricing. Beyond that, these incredibly wealthy hospitals all claim nonprofit status, therefore do not pay taxes, further depriving the city of revenue despite their profit-seeking behavior. Think of all the good we could do for our citizens if we spent that money on city employees and services rather than on wealthy hospitals. New York, New Yorkers everywhere are paying the price of predatory hospital pricing. We are paying for it

directly. We are paying for it with depressed wages and fewer jobs, and we're paying for it with our own tax dollars being wasted. It is time for us to get serious about this problem and use every tool in the tool belt to hold high-priced hospitals accountable. 32BJ is proud to be part of this fight. I want thank the council for holding this important hearing and encourage you to continue to take action. Thank you for your time very much.

MODERATOR: Thank you for your testimony. Um, Council Member Brooks-Powers, I see that you are back on after having dropped off the Zoom. Um, so we see you and will call on you after the chairs and once this panel is complete for your question. Um, and so we will continue with our panel now. I would like to call on, um, Cora Opsahl to provide testimony. You may begin once you're unmuted and ready.

SERGEANT AT ARMS: Time starts now.

CORA OPSAHL: Good morning. My name is Cora Opsahl and I am the interim director of the 32BJ health fund. We provide comprehensive health benefits to union members of SCIU 32BJ and their eligible dependents. We cover approximately 100,000,

190,000 lives in 11 states, with the bulk of our lives here in the New York City area. As a [inaudible] plan our benefits are 100% funded by over 5000 employers, some with thousands of employees and some with only one worker. We provide comprehensive health benefits to our participants with no participate premiums or deductibles and low co-pays. We are also a self-funded plan. This means all medical claims are paid by the 32BJ health fund. While we use an insurance company to administer our benefits, the cost of the care provided to our plan participants is paid by us. That means as hospital and medical costs go up those costs are passed directly on to the 32BJ health fund. The 32BJ health fund receives all of our medical claims. This means we can see where our participants get care and how much it costs. This amount of data has allowed us to analyze our claims and know exactly how we are spending our healthcare dollars. For example, in 2019 the 32BJ health fund spent $929 million dollars on all of our health benefits, including medical, prescription drugs, vision, dental, and other ancillary benefits. Of that $929 million dollars, 82% of the benefit dollar, or $743 million, were

spent on hospitals, doctors, and medical staff. Of that $743 million, 68% of the cost, or $505 million, were for hospital costs alone. That means hospital costs made up 50% of our total spending in 2019. Hospital prices are the number one driver of costs in health care, not just for us but for entire healthcare industry. Over the past decade premiums and deductibles have outpaced wages. That means health care not only got more expensive, but it cost more for patients and plans like ours. As we look at healthcare costs, Medicare prices provide a good benchmark for comparison of commercial prices, or prices paid by self-funded plans like us. We use our own claim data and analyze what we would have paid had we paid Medicare prices for hospital services here in New York City. We looked at our data from 2016 through 2019 and determined that the prices charged for hospital service provided to our participants were 240% higher than what Medicare charged for the same set of services. What that means is had we paid Medicare prices, instead of the high prices charged by hospitals, we would have spent 58% less during that time period. Additionally, we were able to see the high variation between hospital

systems within the city. Looking at just the private hospital systems in New York City, the prices paid by the fund are 316% higher than Medicare prices.

SERGEANT AT ARMS: Time expired.

CORA OPSAHL: To understand what that means in real dollars, let's look at two common procedures, colonoscopies and vaginal births. For a standard colonoscopy the average amount we paid the highest-priced hospital in 2018 and 2019 was $9598. At the same hospital Medicare would have reimbursed $1043. That is 9.2 times the amount Medicare paid for the same routine procedure. Looking at the same time period for a vaginal birth, we paid the most expensive hospital an average of $24,810. Medicare would have paid the, the hospital $9149, or 2.71 times less than what we paid. Setting Medicare aside, comparing what we paid for a colonoscopy and a vaginal birth in a more expensive hospital system to what we paid on average to the rest of the hospital systems in New York City, the difference is still staggering. For a colonoscopy we paid approximately $9000 at the more expensive system, while we paid an average of $4000 at other less-expensive hospital systems. For a vaginal birth, the cost averaged

$24,000 versus $20,000 elsewhere. There is no reason the cost variation should be so high for these procedures. A common justification given for the higher cost is that cost equals quality. However, that is untrue. A 2018 Rand study looked at the correlation between hospital costs and quality. They compared low, medium, and high cost hospitals based on their prices in comparison to Medicare and then looked at the quality data. The results are clear. Higher-cost hospitals do not have better quality scores than those that are medium or low cost. We both have seen this in our own maternity and joint replacement programs. Quality is not dependent on the price charged by the hospital. Lastly, it is important to comment on the anti-competitive nature of the contracts between hospital systems and insurers, and in self-funded plans we make benefit decisions in the best interest of our participants. However, hospital systems can enter into contracts with insurers that restrict our ability to provide high-quality care programs to our participants and to design our benefits to encourage these participants to use high-quality, lower-cost hospitals. For example, the 32BJ fund offers a maternity program for

our participants where they can have a baby for a zero-dollar co-pay if they use one of our highest-quality partner hospitals. Hospitals had to submit an application to be included in our maternity program. We did extensive vetting of the hospitals to ensure they are high quality and would provide an excellent experience for our participants. And our participants are extremely satisfied. But based on the language in a contract between a hospital system and insurance company, we could have been required to shut down our maternity program, which would have taken away the ability for our participants to have a baby with no co-pay. No hospital should be able to exercise this type of control over health plans. It's not fair to our participants or any health plan. In conclusion, high hospital prices will continue to drive up healthcare costs, costing plans like ours millions of dollars in unnecessary funding. Thank you for holding this hearing and bringing light to this ongoing problem.

MODERATOR: Thank you for your testimony. Um, we will now turn to our next panelist. Um, our next panelist will be Geofrey Sorkin. Um, you may

begin when ready and when cued by the, ah, by the sergeant.

SERGEANT AT ARMS: Time starts now.

GEOFREY SORKIN: Thank you very much. Thank you very much. My name is Geof Sorkin. I am the executive director of the United Federation of Teachers' Welfare Funds, and what my organization does is we provide access to health benefits to over 400,000 members. Now, I would like to start today by highlighting that New York City spent nearly 3 billion paying for hospital bills in 2021. That's a 50% increase from the 2 billion we spent just five years ago in 2016. It is time to intervene. Mainly driving this outrageous surge are double-digit increases in hospital costs. We can't maintain this status quo. It is time to address it before it becomes a fiscal crisis. New York City's health benefits program, which we are a part of, is a self-funded insurance plan that pays hospital claims using city taxpayer dollars. To educators and UFT members this means the more money we spend on paying hospital claims the less money we have to invest in education and to better pay our educators. When money is spent on hospitals instead of education it impacts the

city's ability to attract top talent and there's less money to improve our public schools by doing things like lowering class size. Now there is a distinct lack of transparency and anti-competitive behavior exhibited by the largest city hospital networks. They should be blamed for the surge in hospital costs. Hospital contract negotiations are plagued with complicated rules and a lack of transparency with pricing. This ultimately allows the biggest players in the city's hospital system to raise their prices 6% to 10% every year. Presently hospital networks like New York Presbyterian charge two to three times more for routine medical service than other hospital networks that provide the same quality of care. For example, a normal pregnancy delivery at Presbyterian in 2018 cost 50% more than a normal delivery at Mount Sinai, Lenox Hill, and LIJ. Along the same lines, a hip replacement at Presbyterian cost $83,000, while others charge $58,000. Standard hospital admission costs in New York City hospitals range from $12,000 to $36,000 at others. We really need to rein this in and get it under control. This type of disparity shouldn't exist, especially when most are providing the same quality of care. It is

a, it is time to address the gouging. It's time to get more transparency. We need hospitals mandated to disclose pricing information when we negotiate our contracts. We also need hospitals to stop steering from innovative treatments that competitors offer. Those treatments may be less expensive and, more importantly, they may save lives. We need to level the playing field so that all hospitals are on equal footing and we don't have some charging excessive...

SERGEANT AT ARMS: Time expired.

GEOFREY SORKIN: ...[inaudible] compared to others that offer the same quality of care. Hospitals cannot continue to demand double-digit increases every single year while they, excuse me, while they gouge taxpayers and patients for the cost of routine medical care. Again, thank you for holding this hearing today. Our healthcare costs are ballooning. It doesn't have to be that way. We need to address the lack of transparency and the anti-competitive behavior demonstrated by some in the city's system. Together I know we can find a solution before this becomes a fiscal crisis. Thank you very much.

MODERATOR: Thank you so much for your testimony. Um, I've seen we've been rejoined Henry Garrido, who we will call on next. Following Henry Garrido, we will hear from, um, Rene Casiano and Jimmy Brennan. Um, Henry Garrido, you may begin once you are ready and once the sergeant cues you. Thank you.

SERGEANT AT ARMS: Time starts now.

HENRY GARRIDO: Good afternoon, um, ah, Chairs Levine, Rivera, and other members of the committee. My name is Henry Garrido. I'm the executive director of District Council 37, which represented 150,000 active members, almost 100,000 retirees, and we provide insurance for their families and supplemental benefits for their families and their support. I have also co-convened the Coalition for Affordable Hospitals, an issue that has never been more pressing than it is today. Two years ago I addressed this joint committee and identified several reasons, ah, several health costs that have risen in the last decade. I offered then suggestions as to control what was then an unsustainable situation for those that are most in need, ah, of help. Today I appear before you once again to

discuss the skyrocketing cost of health care. Sadly, the situation has not got, has gotten worse. Ah, due to the financial strain caused by COVID-19 pandemic affordable health care is more of a priority now than ever before. It is imperative that all of us do what we can to immediately stem the tide of rising costs. Hospital costs in the New York metro area are among the highest in the country and spending continues to grow more rapidly than the national average. Numerous stories have found the higher hospital pricing does not directly correlate to high quality of care. Instead, every dollar that goes towards costs is one dollar less than could have gone for wages, for workers, and in this case improving government spending, ah, to fund, ah, important public services. To put a finer point on it, fiscal year 2022 is projected that the city will spend 6.9 billion dollars on health care. Um, that does not include supplemental benefits. Um, of that 58% is going to hospital spending alone. Currently we charge 200% over Medicaid. Ah, if we were to charge Medicare rates the city would save 2.4 billion dollars. Think about all we could do to improve public safety, for the homelessness, ah, for schools,

for an additional 2 billion dollars that could be saved as a result of just leveling the playing field. DC37 and our fellow unions, ah, that make up the municipal labor committee, recognize this fact and are doing our part to reduce hospital bills with changes in its design plan of the health [inaudible]. For example, none, ah, we have moved non-urgent but essential procedures, such as colonoscopies and infusion therapy from hospitals to outpatient settings.

SERGEANT AT ARMS: Time expired.

HENRY GARRIDO: We've changed our insurance co-pay structure to discourage members to utilize emergency room less, ah, for non-injured treatment. We implement a wellness program, diabetes, disease prevention programs, and telehelp programs to improve our members' health and prevent hospitalization. And we look to implement, um, every way that we can possible to, ah, rely less and less on hospitals to provide [inaudible] care. Um, I understand my time has expired. We will submit our testimony for the record. But one thing I would say to you is we need to support the HEAL Act that is being sponsored by Senator Andrew Gounardes and

Assemblyman, ah, Catalina Cruz. We need this and we need it, ah, now. Thank you for hearing us, and thank you for your support and your leadership on this matter. We will submit written testimony for the record. Thank you, ah, Chairs. Thank you.

MODERATOR: Thank you so much for your testimony. We will now turn to our next two panelists. Um, I'd like to welcome Rene Casiano to, ah, testify once you are ready and once the sergeant cues you. Thank you.

SERGEANT AT ARMS: Time starts now.

RENE CASIANO: Hello. My name is Rene Casiano. For over 20 years I have worked at Columbia University's Business School as operations staff. I am also a member of UAW Local 2110. I now serve as the full-time union and chair person for the local 2110 bargaining unit at Columbia University. As a union representative I have been part of the bargaining committee at Columbia University and have seen firsthand the impact of the cost of health care on negotiations. At Local 2110 we have been determined to preserve affordable health care for the membership. As a union we have fought hard and have gone on strike to maintain our health care. As a

member of Local 2110, I'm very proud of the strikes that our members mounted, but it is wrong that our members are forced to go through the hardship and sacrifice of a strike simply to maintain what should be the absolute right of every human being - high-quality health care for themselves and their families. Even when we haven't had to strike to keep our health care, the university takes the position that because of the cost of health care we have to take less in wages. Every time we go into, into negotiations with the university the cost of health care hangs over our heads and affects our overall settlement. Our members have to choose between trying to keep affordable health care and having less money to survive in this expensive city, where the cost of rent and transportation is so high. Columbia is a very rich employer with, with a 10 billion dollar endowment. Yet it uses the excuse of the cost of this health care to force the lowest-paid workers to take less, or accepting a worse health plans or low wages. I am lucky enough, I am lucky enough to have a union job that at least gives me the opportunity as a worker to have a seat at the table. What about the workers who don't have unions and work

for employers that don't have such deep pockets? We ask the City Council to do everything possible to take the profiteering out of health care. Ultimately, we need a single-payer health plan. But until we have a federal solution we ask the council to take these interim steps to control hospital costs. Ah, I would like to thank Cochair Levine and Cochair Rivera for, ah, allowing me the opportunity to speak, ah, on the issues that matter. Thank you very much, everyone. Have a good day.

MODERATOR: Thank you so much for your testimony. We will now turn to our final panelist of this panel. Um, I would like to invite Jimmy Brennan to testify. You may begin once you are ready and once the sergeant cues you. Thank you.

SERGEANT AT ARMS: Time starts now.

JIMMY BRENNAN: Good morning, ladies and gentlemen. Thank you for the opportunity to [inaudible] this morning. Ah, my name is Jimmy Brennan. I was born and raised in New York City, and like many of you I'm still a resident of the greatest city in the world. I'm one of nine children and over 30 cousins coming from a traditional Irish American family. We were all born in New York City hospitals

and covered under our parents' union health plans at the time. Having to pay out of pocket for their [inaudible] the New York City hospitals from my generation of my family it would have bankrupt each and every one of our parents, the most important couple at that time and still today. Growing the kid in the concrete jungle [inaudible] my siblings and I were no strangers to emergency rooms, basic medical needs [inaudible] require as they grow are not an option, they are a necessity. Fortunately our parents were able to secure positions as union workers whose benefit package provided a healthcare plan for them and their families. Without their health benefits our parents would have accumulated debt and it would have prevented them from keeping their commitment, give their children a higher level of education and a better life than they receive, as almost every parent sets out to do. Having grown up in a union family, when I became of age I set out to secure a union position that provided me the same security and the same benefits I grew up with. I was first hired by Manhattan Property as a doorman [inaudible] and four years later at a different property in Manhattan I became a superintendent at

21. I am now a resident manager on the Upper East Side, where I have worked for the previous 19 years. As with [inaudible] my need for medical attention was minimal, if any [inaudible] I didn't require much from my medical benefits plan. As a young guy [inaudible] every Thursday, ah, for a check on every Thursday, rather, um, I felt my union just would waste money when they would deduct it from my paycheck. And that all changed around at 26. In [inaudible] I suddenly became severely ill and the cause could not be diagnosed by my regular doctor, nor the specialist he recommended. Due to the lack of diagnosis, my illness progressed and as a result of constant vomiting I lost 80 pounds in two months. I was forced in December of 2006 to admit myself to Lenox Hill Hospital because of the illness [inaudible]. The hospital stay this time was for 29 days. I was unfortunately placed in ICU because air had entered my chest cavity, which can cause severe cardiac arrest if not removed. Having a priest come to give last rites and having your father throw him out of the hospital room was a very unique moment for me at 26. And I was diagnosed with gastroparesis, which is a paralysis of the stomach muscles. It is a

rare disease that affects about 2% of humans worldwide. So, yeah, I, I hit the lottery you don't want to hit. Um, once my vomiting was brought under control in the hospital I was allowed to go home, and then forced to change my lifestyle and completely change what I eat. It was a very difficult process to go through as a young person of 26. Over the next eight years I was hospitalized regularly because once the vomiting reached the point where blood was the only thing that come up, only hospital care would stop the vomiting. I've been a patient in every main hospital in New York City and a few outside our boroughs.

SERGEANT AT ARMS: Time expired.

JIMMY BRENNAN: ...[inaudible] testing and continuing doctors' visits for that eight-year period [inaudible] half a million dollars. If I was not a union worker who had medical benefits at that time I may not be here today to tell you my story. If I were to meet some of those costs out of pocket I would have had to work the next 30 years to pay those costs. Because I am member, a proud member of Local 32BJ, who has an outstanding medical plan for their members, I stand before you here today. In 2010 I

was asked by the leadership of 32 [inaudible] specifically to join their executive board here in New York. Shortly thereafter I was appointed to serve as a committee member of the bargaining committee for the [inaudible] contract negotiations that cover some 40,000 workers here in New York City. [inaudible] leadership works during every negotiation just to maintain the benefits that we already have to here. In our last bargaining session 40 cents of dollar we secured from our employers and the allocated to keep our health plan for our members. Given the cost of living in New York City, we strived to secure increases in our contract to keep with the cost of living. Due to the fact that hospital and medical costs rise higher annually than the cost of living and most other products and services, it is almost impossible for us to secure wage increases while our healthcare costs continue to skyrocket at uncontrolled and unprecedented rates. Our health fund directors work diligently to ensure that the funds in our healthcare fund are properly allocated on behalf of our members. Hospital price gouging is one of the leading challenges that we face as a union today and it's the largest driving factor for the

increase in our healthcare costs. The rate of increase of hospital costs are not sustainable. This coming April we'll begin a new round of bargaining for our 40,000 [inaudible] here in New York City. These men and women for the first time in over our 80-year history of 32BJ achieved the title of essential worker during the pandemic. Our membership every day they performed and served our city and went through the largest exodus in our city's history, it [inaudible] free, it didn't secure themselves in their bunkers. What [inaudible] do? We don't do that. We do what we're trained to do and that's run New York City. And with zero interruptions in the services provided by our members and their properties across this great city. The [inaudible] shared one of the highest death rates during the peak of the pandemic. Due to the pandemic the importance of maintaining our quality health care has never been more of a priority for our leadership. Now more than ever we must stand together as one, fighting hospital price gouging, maintain our health benefits, and thus our quality of life so that we continue to serve this great city as we have for the last 80 years and for

the next 80 years to come. Thank you for this opportunity.

MODERATOR: Thank you so much for your testimony. Um, we will now turn to the chairs for questions. I'm first gonna turn to Chair Rivera.

CHAIRPERSON RIVERA: Well, thank you so much for being here. Just a, a couple general questions. Some of it was touched upon in your testimony and, again, I want to thank you all for your time and your patience in staying, um, ah, to share your words and some of the experiences of your members, direct experiences clearly. But what have your members' experiences been like with seeking care within New York City hospitals and what more can the city do to assure affordability across our hospitals? I know they're fairly different questions, but if could just pose that to the panel, anybody who would like to weigh in. What have your members' experiences been like, ah, with seeking care within New York City hospitals and what more can the city do to ensure affordability across our hospitals?

KYLE BRAGG: Um, thank you, ah, for that question, ah, Councilwoman. Ah, first I'd, you know, our members are receiving, ah, good and quality care,

ah, in the hospital systems in New York City. That's not what's at issue here. What is at issue is them receiving the quality of care, ah, from these, ah, healthcare professionals, but, ah, us having to pay these outrageous, ah, ah, costs due to the pricing, which is totally subjective. As you know, you know, you know, we, the healthcare professionals that provide the care to our members are, again, providing excellent care to our members. The problem is that it shouldn't vary across hospital systems. We shouldn't have to pay double the amount for a procedure from, from one hospital to another. It just doesn't add up. I've heard them talking about operational costs, but it, or, or, or whether you're in a teaching hospital. There are teaching hospitals in the, in the pricing, ah, that exists for procedures, just don't equate, you know, to, to the, to that, to that explanation. So, um, I think that what the city can do is to continue to push back against, ah, what is happening, ah, to, to these hospital systems about this, ah, unfair and unjust and very subjective pricing, ah, ah, policies and procedures because the dollars that they spend, which I think is somewhere near 7 billion, and if, and if

it's relation to, ah, to our health fund spend it'd be half of that is, is coming from hospital, ah, ah, prices. And so that's money that can be going back into the coffers of our city and going back into the pockets of workers, ah, of this city.

CHAIRPERSON RIVERA: What...

HENRY GARRIDO: My, ah, Madam Chair, some time ago, about, I would say about four or five months the city, the unions, had meetings with some of the hospital heads, um, that in order to have conversations we'd say, listen, if, if this situation continues where the pricing is so vastly different for the same services we may be forced to do some other things, like an RFP or something to that [inaudible]. Some of the hospitals came in very candidly and said there are things that we can do to improve access to quality care. Ah, institutions like Sloan Kettering Cancer Center came in and said, you know, we, we want to make some of these things available to your members and, and to the workers. Other hospitals, like Columbia Presbyterian, refused to meet with the city and the unions. That says a lot, when the City of New York, convened by the mayor [inaudible] unions representing 1.3 million lives

convened meetings with the hospitals and some of those hospital systems did not even have the decency to reply. And so it makes the conversation very difficult because their bluff is if you don't want to pay out 60%, 75% over the other hospitals then we'll just put you out of network and your members will not have access to that care. And that to my is a, is a mentality that needs to change. And I think that one of the things the city could do and the City Council can do is, as my brother Kyle said, continue to push for transparency in billing. I think if people were to see more clearly what we're being charged with I think the situation would [inaudible], it would change completely. And I think that we need to continue to [inaudible] and a lot of the hospitals have made it clear that they don't want that transparency and billing to be clear, to be, ah, apparent. And I think that's one of the ways that the city could help us.

KYLE BRAGG: Well, I would add that, um, you know, what we've done was extrapolate from our own, ah, ah, payments, ah, the hospital payments from our fund, assume that the city spends, ah, pretty much the same percentages on their healthcare

expenses and hospital costs, and I think that if, ah, we were able to, ah, join, ah, with the city, ah, to, ah, use our collective buying power to demand, ah, fairer, ah, hospital prices that would be something that, ah, would certainly go a long way to attacking this issue.

CHAIRPERSON RIVERA: I agree and, and I know that, um, they're hearing our message loud and clear. You know, I, I, I have a bit of, ah, about the health fund because I know how important it is to your members and, and anyway can weigh in. I know Corey certainly can. Many union health funds, including the 32BJ healthfulness are self-identify, which means that they pay all members' bills for care, and so my understanding is that 57.5% of New Yorkers who have health insurance are in self-insured plans. Is that your understanding as well?

KYLE BRAGG: Ah, I'll, I, I trust those statistics and I believe that that's right, um, and, again, you know, Empire doesn't make more or less based upon how much we pay or how much health care we use, you know, and, you know, we, you know, we have a flat fee. You know, our problem, again, is that, ah, you know, we can't have, ah, one, there's no

transparency in how, ah, these billing practices, ah, are taking place and are, are formulated, ah, and, ah, we don't, we don't particularly have a say in, in how, ah, ah, these hospital systems, ah, create these, ah, these, these, these, billing, billing standards. So, um, you know, I, we don't, we don't have, ah, particular love for anything in this system that, ah, takes advantage of, of patients. Ah, but we believe that there is a serious problem, ah, in that this hospital pricing, ah, is, is, is so out of whack and, and varies across the systems for the same procedures, that this, this has, that something has to be done about this, and we believe that the uniting with, ah, those other private funds and with the city, ah, using all our collective buying power can, can deal with this, ah, ah, issue.

CHAIRPERSON RIVERA: So when Empire's acting as your third-party administrator they, they don't make a profit based on the cost or level of utilization of those healthcare services, that's correct?

KYLE BRAGG: I would, I would say that, I wouldn't say that's correct. I wouldn't say that they don't make a profit, but what I would say is

that we get to negotiate with, ah, Blue Cross and Blue Shield but we pay them provide the service that they provide to us. What we don't get to do is negotiate with the hospitals about, you know, their, their pricing, ah, practices and, you know, how it varies across hospital systems. It's just ridiculous that you can go to, ah, two hospitals within, as I think, ah, Council Member Levine has stated, within the same borough, within a matter of miles of each other, and you pay thousands of dollars more for one procedure than you pay for another. And, and it just doesn't add up. It doesn't make sense. They, they, they have the same operational costs. Ah, what I didn't hear from, ah, Mr. Rich about how he explains that, ah, that, that, that price variance, ah, when they all, ah, function under the same, ah, ah, ah, operational costs.

CHAIRPERSON RIVERA: Oh, correct, and I think that's, you know, those are, those were the, the big questions that we have, is that you could have hospitals that are literally blocks away from each other and the disparities are, are wild. So I, I want to just thank you all for being here, for answering my questions. Ah, I'll, I'll turn it over

to my cochair to see if he has, ah, any follow up questions for this, ah, esteemed panel.

CHAIRPERSON LEVINE: Thank you so much, Chair Rivera, and thank you to this panel. Um, Executive Director Garrida, you brought up a point which, ah, is so critical that I don't know if the public realizes that this crisis of, of pricing and hospitals directly impacts city government. It impacts our budget. It impacts the resources we have for all sorts of vital programs to deal with challenges in the city that you enumerated, from education to housing, etcetera. Um, and you said a couple numbers that were just incredibly big that I, I want you just to repeat because they're so important. But, um, you said that if hospital pricing simply was in line with what is paid for Medicare it would save, ah, literally billions of dollars. Could you just clarify that point?

HENRY GARRIDO: Yeah, I mean, we could save over 2 billion dollars in just by leveling the playing field and, and if we were tie or index to cost of living. And I think that's pretty telling, right? Ah, in a city where it's the same, because it's the same hospitals, right? And it's the same

population, to some extent. And the reason why I use Medicare as an example is because older adults tend to cost more, right? They have more complications in health than, than others. So even if you use that as a measurement you would save 2 billion dollars. Um, I use this example quite often, right. When you look at the city budget, ah, since FY2019 the largest growth of any expenditures by the city has been health care. And the number one reason for that has been hospitalization and the cost of, the rising cost of prescription drugs. Hospitals, much more than drugs, than prescription drugs, that's a fact that we pay, ah, 3 billion dollars to provide health care for city, ah, workers, ah, and less than a billion of that was going to hospitals. Today that number is over 4 billion dollars in, in the matter of, of, you know, a few years. The cost doesn't seem to be associated with any major, you know, real estate expansion [inaudible] 'cause it's the same problems, right? The cost doesn't seem to be associated with [inaudible] wages and increases of the workers. It's pure price gouging. It's the idea that they provide what they provide and they can charge what they can charge, and we have the option to either pay up or be

out of network. And that's incredibly unfair to the, the city workers, to the working people who have for years maintained those very hospitals, even when some of the [inaudible] was questioned. And so I think that we are at a point that if we continue to do this we're going to collapse the health insurance benefit. I had all this discussion about Medicaid and Medicare Advantage and everything else. Guess what? The hospitals are one of the primary reasons why the cost of health care is threatening to undo the benefits that those people fought so hard to get.

CHAIRPERSON LEVINE: Exactly, and as we said here throughout the hearing the US is spending far more in health care than any other peer nation. But we're not getting more health care out of it. We're not getting better health outcomes out of. We're just overpaying and that, that unfortunately is true in New York. Um, we've talked about that, that hospital pricing is so opaque that it's, it's hard to even, ah, get a fix on, on just how wide the disparities are for the same procedure in different hospitals, though we know it's, it's significant and for that reason the work that, that 32BJ has done is really important. You all have put some, some brain

power and even data analytics in to try and getter a better fix, ah, comparing procedure to procedure, hospital to hospital, and you've come up with some pretty incredible examples. But I have to say that the example, and, and I don't know if [inaudible] on this, but the example that you all kept come up with, with differential in, ah, maternity costs for, ah, traditional births is pretty shocking. So maybe Cora, 'cause I, I think you probably have done a lot of research on this. Could you just illuminate that again? What is happening with the price disparity on, um, those birthing procedures?

CORA OPSAHL: Sure. So we'll just a simple vaginal birth or, you know, as our, our example. What we found is in 2019, the average that we were paying in 2018 and 2019 for our highest-priced hospital was $24,000, but what we paid on average all the rest of hospitals was $20,000. Our most recent statistics, when we started to look it, actually the cost difference is closer to $28,000 to $20,000. So when we really started to look at this is these higher-priced hospitals are just continuing to charge more and more than what, you know, their, their, ah, their partner hospitals, um, are charging.

CHAIRPERSON LEVINE: It, it, it is so painful to hear that even in a procedure like that, ah, there's such profound disparity, ah, and we know it impacts workers, it impacts unions, it impacts ultimately city government, ah, in, in really negative ways. Um, I, I know that we have, ah, Council Member, ah, Brooks-Powers waiting patiently to ask a question, so I'm gonna, I'm gonna stop there. But I want to thank this panel for raising the alarm on this issue, ah, for the work you've done, ah, to build, ah, the case here and for your advocacy and leadership. Um, we're, we're proud to stand with you, ah, in this fight. Thank you.

MODERATOR: Thank you, chair.

CHAIRPERSON LEVINE: And I, I'll guess I'll pass it to Ann if you want to cue, ah, Council Member Brooks-Powers.

MODERATOR: Thanks. Thanks, Chairs. Um, so as a reminder for council members, um, you can use the Zoom raise hand function if you have questions and I'm going to turn it now to you, Council Member Brooks-Powers.

SERGEANT AT ARMS: Time starts now.

MODERATOR: OK, so it seems like we may have some, um, technical difficulties getting Council Member Brooks-Powers so we will reach out to the council member. Um, seeing no other hands, I will now thank this panel for testifying and we can turn to our next panel. Um, so our next panel will be Anthony Feliciano, followed by Christin Deacon, Amanda Dunker, Cynthia A. Fisher, and Mark Zezza. So I would like to invite Anthony Feliciano to testify. You may begin when ready and once the sergeant cues you to begin.

SERGEANT AT ARMS: Time starts now.

ANTHONY FELICIANO: Good afternoon. My name is Anthony Feliciano. I'm the director of the Commission on the Public's Health System. I would like to thank the City Council Hospital Committee and Health Committees for holding this hearing today. Ah, I wanted to begin with saying that disparities are also found in the quality and the care provided by the healthcare system, especially for black, indigenous, and people of color. For the, um, sense of time right now I won't go over every piece, but my testimony covers several factors contributing to the disparity around costs and care, the quality of it,

um, and their, um, aspects of this. But I want to go directly to the recommendations given that I have a short amount of time. Um, I believe that New York City Department of Health, the city comptroller's office, along with the City Council could jointly conduct an analysis comparing the actual cost to care for similar patients in different hospitals, and those are also what the unions have been doing. Currently the city DOH does review together both hospital and institutional [inaudible] costs, which are ICRs, and patient-specific discharge data to SPARCS. However, it may need some reliable variables that could be married to current data collected. This is important because costs derive from billing data, ah, based upon what is submitted by our facility to the state and may not necessarily reflect a final price of the service delivered. The other recommendation I would say [inaudible] in hospitals with high-cost services for common diagnoses that are displaying lack of services to low-income immigrants and communities of color, especially for self-paid, uninsured individuals and families. The Centers for Medicaid, CMS employment did a rule on January 1 that required hospitals to post their standard charges

online. And while we understood from advocates that there are still issues, New York City can [inaudible] we are better, include looking at the relationship between hospital cost data and over [inaudible] price index to see any correlation between the cost and medical services and overall cost of living as well. Access to the socioeconomic impact [inaudible] City of New York is providing we also should look at the 669 million or more in real property tax exemptions to private and not-for-profit healthcare providers. The city and the state should reconsider the tax benefits, the permitting, and the zoning exceptions awarded to private and voluntary hospitals if it's not about caring for the sick and creating fair costs for services and treatment. Also, create a citywide stakeholder group that has equal representation of community advocates and labor, 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. My other recommendation is the City Council should pass Intro 1674, which establishes an Office

of Hospital Patient Advocate that I know, um, Councilman Carlina has been advocating for. And use that ability for that office to help with around price transparency as well. We also think we have to monitor closely all the hospitals and health plans to ensure that validating measures do address both disparities in costs and care, especially as Medicare...

SERGEANT AT ARMS: Time expired.

ANTHONY FELICIANO: ...especially as Medicare reimbursement transitions from fee for service to value-based purchasing. I would add that we should discuss ways that the committee and city healthcare services could review both current workforce and community access to affordable health care and prices. The committee was created under Local Law 6 in 2018. I think we need to revisit Intro 973-A, which was amended in the Charter to establish an Office of Comprehensive Community Health Planning and Interagency Coordination Council on Health. I also believe that we should continue advocating the governor at the state to sign bills around the indigent care pool. Obviously the indigent care pool will create some equity issues

that we've been seeing around recipient dollars there. I also understand we [inaudible] address the state HEAL bill, um, and, and we know that it's improving hospital pricing transparency and, and the anti-competitive hospital contracting practices. However, some of the provisions will have unintended consequences around access, patient choice, and overall support for wellness initiatives. I refrain to add more because we believe that these areas can be discussed with 32BJ and our labor partners, one of the main advocates for the bill. We respect workers' rights, share contracting over benefits, and labor, and the labor movement. We serve and work with and protect the same communities, especially people of color and immigrants. For that reason we do not want to fall trap to the power and control fight between and the manipulation fostered by the hospital association and insurance industry association. We have common goals with unions around cost transparency and affordability. I hope both parties can come to an understanding around both [inaudible] and work through each of our interests and concerns, particularly the workers' right. At this point we are not in support of HEAL. However, it does not

mean we would not be in the near future based on what has been stated in my [inaudible] testimony earlier. And once again thank you for this opportunity.

MODERATOR: Thank you for your testimony. We will now turn to our next panelist. Um, Christin Deacon, you may begin once the sergeant cues you and once you are ready. Thank you.

SERGEANT AT ARMS: Time starts now.

CHRISTIN DEACON: Thank you. Um, so our, ah, I want to start with a quote. Um, our hospital's mission is to provide caring, high-quality, fiscally responsible healthcare services that meet the needs and expectations of the communities we serve. This is a prominent New York hospital, um, and I think this is a real example of a mission statement from, you know, one of your hospitals, but also it's similar to those of all the other hospital systems in your city, um, indeed the state and the country. While I don't question the core mission of providing care and high-quality healthcare services to the communities they serve, I do, ah, question the proposition that there is any element of fiscal responsibility when it comes to hospital prices. I acknowledge and understand that there's never a good

time to take on hospital prices, ah, especially given the pandemic. Um, in addition, policy makers are often pressure to protect their local hospitals and avoid much-needed discussion about hospital pricing and transparency. But, um, that task is essential if the nation is ever to get a grip on healthcare costs. Fully half of Americans now carry medical debt, up from 46% in 2020. Rising hospitals prices are substantially to blame for this unacceptable state of affairs. As the former director of the State of New Jersey health benefits program, which represents, um, about 820,000 lives across state employees, local government, and educational employees, I not only have a unique perspective, I have a unique experience in dealing with the rise of healthcare costs. Um, you know, so aside from sort of this medical, ah, debt that is crushing our middle- and lower-income classes and disproportionately impacting our communities of color, um, and those most vulnerable among us, why should we care about rising hospital prices. As employers and public leaders, um, what can we do about it? So the why. First, you know, hospital spending comprises the biggest chunk of healthcare spending, which drives up insurance

premiums and out-of-pocket costs to our, um, members. Even if you have a generous plan, um, like some of those discussed, um, with low out-of-pocket costs or no co-pays and deductibles, shielding your employees from the exorbitant costs of health care in the near term, it does not shield them from paying for it in different ways. Um, the main ways in which all of us, even those with Cadillac plus plus plans, are, um, in fact paying is their increased health benefit premiums the following year. If you're fully insured, um, or self-insured, increasing an exorbitant hospital cost, um, which, again, I think was pointed out, have zero correlation to quality, will be passed on in the form of higher premiums the following year. Um, some public sector unions or groups, like some of the ones I worked with in the State of New Jersey, pay a percentage of their salary for health benefit contributions, so they felt that they were...

SERGEANT AT ARMS: Time expired.

CHRISTIN DEACON: ...protected, um, you know, wrong again. If increasing hospital costs lead to a net increase in healthcare expenditures for your employer, there will be invariable, invariably less

money, um, for compensation and raises, pension funding, etcetera. And finally if you're one of those unicorn organization that sort of foots the entire bill for your, your employee, I'd like to think, you know, more, ah, broadly about the opportunity it costs that these high-cost hospital costs, um, lead to. If one dollar out of every three healthcare dollars is spent on hospital costs, that represents today roughly 6% of the United States GDP. We spend less than 4% on education, less than 1% dealing and preparing, ah, for climate change disasters and less than 2.5% on infrastructure. Um, a percentage too small to even quantify on food insecurity. Are we getting better health outcomes? No. Is hospital care improving our health as a nation? No. Um, I think it's important to sort of talk about the narrative as well, um, that we heard this morning. Um, you know, there are hospital executives that will take issue with this position and have on the record. And I've heard the plethora of reasons why quote hospital prices continue to rise and, and they go something like this. Um, public payers like Medicare and Medicaid under pay. Um, false. Medicare and Medicaid rates are not enough to

sustain our business model. False. Um, we know that commercial payers reimburse hospitals two-and-a-half times more than Medicare on average. Yet, according to MEDPAC, the congressional advisory commission that sets reimbursement rates with multiple stakeholders' input, including the hospital systems. Medicare payments are structured to cover 8% more than hospitals allow variable costs. Perhaps 8% is too narrow of a margin, but is 250% to 400% really necessary? Another comment being, oh, but charity care. Ah, nope, again, not buying it. See the statistic above on medical debt and in addition it's pretty easy to learn about hospitals' case mix from their public CMS filings and I have personally challenged this narrative, um, with hospital CEOs in New Jersey when they cried charity care at a cost control advisory meeting. After pointing out that this particular institution's charity care as a percentage of case mix was under 2% I pointed out that the 32% profit margin could more than adequately absorb these costs without charging the state health plan, um, ah, multiples of CMS for services provided. An analysis by Politico found that since the Affordable Care Act coverage expansion, revenue in

the top seven non-prof hospital systems, um, increased by 15%, while charity care, um, the most tangible aspect of community benefit, has decreased 35%. Another thing you will hear is oh our community impact. We cannot rubber stamp this category either. Um, fountains in glass atrium are not positive community impact, nor should a hospital's acceptance of Medicaid patients, um, constitute community benefit either. Ah, while there are legitimate ways in which hospitals can and do give back to the communities they serve, the local community that is footing the bill and the hospital's tax break, um, must have a say, ah, in how that money is spent. No I'm gonna quickly give you some very specific statistics to back up some of my claims taken from your very own hospitals in New York City, based on their own public filings with the Center for Medicaid and Medicare Services. Net profit margins range from New York City Health and Hospitals System from a -12% profit margin to New York Presbyterian topping at 19% profit margin. Net assets range from a negative from some systems to, um, on average most in the hundreds of millions sitting on assets to the higher side of Mount Sinai sitting on almost, ah, 2.5 billion, NYU

Langone over 3 billion, and New York Presbyterian sitting on assets of over 8 billion dollars. With the exception of three hospitals in New York City, all have less than a 1% charity care case mix, while at the same time the majority of these hospitals are charging multiples of the CMS rate, one in particular averaging over 380% of CMS for all inpatient and outpatient services. There is no amount, um, put simply, of charity care community impact that could justify such exorbitant costs that are borne by the city's taxpayers, employers, and employee residents. There is no obvious check to balance out the increasingly one-sided market that health benefits, ah, health, that benefits from higher health care and hospital prices. Horizontal and vertical consolidation amongst hospital systems, the purchasing of physicians' offices, um, really preying on them during the pandemic, and the buildings freeze, um, in terms of actually land capital, that these acquisitions have spawned, are only leading to more upward pressure on hospital prices, if we do not stand up and say I'm mad as hell and I'm gonna, I'm not gonna take it any more. So now that we've spent most of my time talking about why it matters, um,

sort of the easy part, now what can we do about it? Demand full transparency. The federal government has tried, ah, through rule-making to force hospitals to be more transparent with their prices, but due to meager enforcement and a lack of willingness of the hospitals to comply, we are left with little meaningful information. We must demand transparency through your self-funded contracts, um, through, ah, your purchasing clout, and in law and regulation that you may control. You pay for it. Demand to know the prices. Um, recognize that you have the buying power and use it. Self-funded payers have the market power to demand lower costs. The City of New York is the largest health purchaser in the city. The train, the train will only keep running away if we stand idly by and watch it, and if a hospital is charging exorbitant fees, remove it from your network. Save your employees and your bottom line from these predatory practices. Um, I recognize my time has long passed, so I, I will stop and I am going to have to step away at 1 o'clock.

MODERATOR: Thank you so much for your testimony. We will now turn to Amanda Dunker.

Amanda, you may begin once you are ready and once the sergeant cues you. Thank you.

SERGEANT AT ARMS: Time starts now.

AMANDA DUNKER: Um, I'm Amanda Dunker. I'm the health policy director at the Community Service Society of New York, which a 175-year-old charity, um, in the city that advocates for, for low- and moderate-income New Yorkers. Um, before I start I would like to recognize the extraordinary sacrifices that front-line hospital workers of all kinds have made during the pandemic. We're aware of those sacrifices and as New Yorkers we are so grateful for them. Um, the healthcare [inaudible] at CSS serve 130,000 people every year. Um, and what we do is help people enroll in health insurance and then use it to access and afford health care. The people we serve have every type of insurance - public, private, fully funded, self-funded, and we also, um, help people who don't have insurance. What we know from that work is that patients in New York are stuck in the middle of a battle between titans, so insurers on one side and hospitals on the other and patients in the middle. Our written testimony describes the consequences of [inaudible] on the disparities the

system produces. Patients don't get care they need. They end up being put in collections. And they're even sued by the thousands by hospitals by hospitals in New York, even though all of those hospitals are nonprofit [inaudible]. In a survey we did in 2019, New Yorkers blamed hospitals and insurers equally for their plight, and 69% said the hospitals charge too much. In that they are correct. Inpatient prices in New York State are 241% of Medicare prices on average, which is the highest in the entire country. New York City doesn't have authority or control over a lot of the factors that contribute to those high prices or the fact that, that patients are sort of stuck in the middle between these two big players. Um, a lot of the solutions that we endorse have to occur at the state level. So, for example, during the 1990s New York State abandoned a statewide system of rate setting, um, and health planning. Um, and that system had ensured that safety nets were receiving enough financial support to survive. When we lost that system we lost a third of our bed capacity and we are experiencing the consequences of that, um, in terms of disparities in mortality rates during the pandemic. Um, the state could restore

those systems. The state could look into strategies like Massachusetts' health policy, health policy, um, cost commission, or Maryland's below payment system and it could enact a single-payer like the New York Health Act. And CSS would endorse any of those approaches to controlling costs for patients. Um, respectfully, we don't, we cannot endorse an approach taken like that in the HEAL Act legislation others have mentioned today. Um, the HEAL Act is an attempt to adjust a balance between those titans. But we think and we are concerned that it does that in a way in a way that might hurt patients. Um, its provisions could encourage [inaudible] that are so difficult for patients to navigate. Um, and we feel that the price transparency provision in the act does not go far enough because it would not increase price transparency for the public or the government. Um, we supported a policy last year as part of the Patient Medical Debt Protection Act that would have gone a lot further. Um, there are some steps that the City Council could take...

SERGEANT AT ARMS: Time expired.

AMANDA DUNKER: ...[inaudible] are, are nonprofits. Ah, the city could investigate their tax

exemptions and zoning rules as they apply to hospitals. Um, ah, Anthony I believe mentioned the Office of Patient Advocate. We endorse that, um, as a way to listen to patients and give patients a way, a place to go when they're having issues. Um, and finally we think the council could augment funding for community-based organizations that help people enroll in health insurance and then make sure that they can use it afterwards. So [inaudible] Access Health NYC, um, and the Managed Care Consumer Assistance Program we think are at least a way to help navigate, um, navigate the system until we take some of those bigger steps I described at the state level. Thank you.

MODERATOR: Thank you so much for your testimony. We are now going to turn to Cynthia A. Fisher, followed by Mark Zezza, and Raul Rivera. So, um, Cynthia A. Fisher you may begin once you are ready and once the sergeant cues you.

SERGEANT AT ARMS: Time starts now.

CYNTHIA A. FISHER: Thank you very much. It is an honor to, ah, be here today, ah, with the New York City council members and I thank you, Chairman Rivera and also Chairman Levine, ah, for the

opportunity to speak. I am Cynthia Fisher. I am founder and chairman of patientrightsadvocate.org and we are a nonprofit, nonpartisan, um, organization that seeks to have real prices, actual prices, ah, disclosed through price transparency, ah, giving all patients and consumers, that being employers, unions, taxpayers, patients, and their family members alike, the ability to know and see prices up front, benefit from competition, be able to compare prices, and through their own choices, ah, be able to get the best quality of care at the best and lowest possible price. We believe very firmly that the foundation of price transparency, healthcare price transparency systemwide, beginning with the hospitals and followed by the health insurers and plans showing all negotiated rates and all prices will create a competitive functional marketplace where all employers, unions, and workers alike, as well as those on Medicare and Medicaid government, ah, backed systems would be able to know the real prices. The beauty in price transparency is it will usher in quality transparency as well. And that would be transparency in services as well as outcomes. This is a huge win because price discovery will also usher

in just what is the standard of care. What is the standard of care for a mammogram and what should it cost? And we spoke today earlier with Cora's data of the prices and standard of care for childbirth. What is the standard of care and what should it cost? Those answers will all be disclosed when we have a functional, competitive marketplace in health care. Well, the great news is that we have the support of three presidents - President Obama in the Affordable Care Act, ah, and also put into law patients' having the right to know up front all charges in health care. That Affordable Care Act law was put into rule of law during the Trump administration, and now embraced by the Biden administration, and in fact because the hospitals have not been complying with this law President Biden has put in place an anti-competitive practices organization to look at anti-competitive behavior of the hospitals and for not complying raised the penalties. Um, however, we at...

SERGEANT AT ARMS: Time expired.

CYNTHIA A. FISHER: ...we at patientsrightadvocate.org in July did a report on 500 random hospitals in this country and looked at the

compliance of these new laws. Remember, the American Hospital Association and hospital associations like Mr. Rich's all got behind a lawsuit to keep patients in the dark. They sued to not have this law be enacted and in place and rule of law to keep patients in the dark, blind to know prices, and able to surprise with large, outrageous, sometimes overpriced medical bills being blindsided, and then making every patient, whether they have coverage or not coverage or various coverage pay with a blank check. Well, this is game over, because the American consumers won in the courts and the hospitals as of January of this, 1st of this year, are to post all negotiated rates in an easy to download, machine readable and human readable file where anyone can see every single payer, every single plan, negotiated rate, as well as all discounted cash prices. And cash prices are oftentimes even lower than the negotiated rates because the hospital gets its money up front. But we don't have access to that when hospitals don't comply. And what we found is only 5.6% in our report, which I'm happy to submit with my testimony, only 5.6% of the hospitals of those 500 were fully compliant with this new law. And as Mr. Rich said

earlier, they've bee, some of the New York hospitals have done cost estimator tools. That's only one small facet of this. The most important thing that these hospitals are to comply with is to unleash the actual prices, the actual data in that file, so that any tech innovator, any consumer, and all of us can be able to have access to know real prices up front and patients know they benefit when they can get an actual and binding price rather than an estimate. Why? Because binding upfront actual prices are accountable and estimates are useless because they're merely a range with no accountability to the hospitals for those prices, and patients find the estimate tools do not help them when fighting a bill. However, price discovery, price transparency does. I have to report to you today, and I can submit this as well in my testimony, is we found, we looked at 20 hospitals in the New York State, most in New York City, of which none were compliant fully with this law. Do know that we know from Health and Human Services that it only costs a hospital approximate $11,868, which is what the OMB office, the federal OMB office and HHS concluded to post this, these, this data online. So going forward, um, the beauty

is, is that we will do another report as of January of next year, adding a thousand hospitals to our list. But the foundation to lower the cost of health care for all of us is for the New York City officials to weigh in to support that these hospitals must comply with this law. Support to this administration, um, seeking even higher penalties, demand hospital prices from the CEOs and the CFOs of these hospitals, and know that next year as of July 1, 2022, all health insurance plans also have to show all of their negotiated rates and put it everywhere we have in the health system the ability for all of us to know actual prices negotiated by each and every plan, as well as the historical claims data on what prices actually get paid to the hospitals. Getting access, all of us, to this data will show us what hospitals are actually being paid by these health plans and what we're seeing already from the health care hospitals that are posting their prices and those that we can in the system that are beginning to compete, we're seeing huge price variation, not only across hospitals, but we're seeing huge price variation within the same hospitals. In fact, I can report that in New York City that we saw not just

what Cora experienced as a $24,000 average on a vaginal birth, but we saw vaginal births, normal healthy vaginal births, coded similarly, in the same New York hospital, New York Presbyterian, being at $85,000 to an individual patient. We've seen EpiPens priced at $15,000 amount coming out of a hospital, when had the patient not been handed that Epipen from that hospital but gotten merely a prescription, they could have gone across the street and gotten it for less than $100. We've helped fight these bills for patients because we can see prices. But we know now patients are also fighting their medical bills when they go in they search by their plan what was the negotiated rate and what was the hospital price. Already consumers are winning. But the real power is in all of us as a collective. Self-insured employers through the ERISA law have the right and by law are the fiduciary for the welfare and health benefits of their employees. And just like what happened in the financial services industry all of the rates and, and, and brokerage fees for retirement funds had to be made transparent. That is in ERISA law. So every self-insured employers can share collectively and demand through a demand letter of their plan to get

access now, before next July, to get access now to all of the actual negotiated rates by their plans, and there is absolutely no reason why as a collective, we as unions, we as, um, nonprofits and businesses can't, and even New York City Council can't come together and demand this actual data today and then do the analysis and compare, and then forward, steer our employees and workers to the best cost, ah, the best quality of care at the lowest possible prices. I thank you for this time today and I, um, think we have a great opportunity that lies ahead in the coming year, in two years, um, putting consumers in the driver's seat and all of us to have to right to have lower-cost health care, broad access, and it be quite simple through a competitive functional market. Thank you.

CHAIRPERSON RIVERA: Thank you.

MODERATOR: Thank you so much for your testimony. We're now gonna turn to Mark Zezza from New York State Health Foundation.

SERGEANT AT ARMS: Time starts now.

MARK ZEZZA: First of all, thank you Chairperson Rivera and Chairperson Levine and members of the committees for the opportunity to testify

before you to discuss hospital prices and health care price variation. I am Mark Zezza, director of policy and research at the New York State Health Foundation. The foundation is a private, independent, charitable organization that operates statewide and has the mission of improving the health of all New Yorkers. The foundation, like, like others who have spoke already believes that information transparency is a gateway to improving affordability, quality, and competition in the healthcare system. You have heard from others about how New York State has been consistently shown to have high healthcare spending in comparison to the rest of the country, with the growth in prices being the main driver of spending levels. Historically, there has been little transparency in prices and when prices are revealed we see a great deal of unwanted variation. In 2016 the foundation funded a study by Gorman Actuarial to investigate the main drivers of price variation within the hospital industry. Gorman worked with the state to obtain price data, including the actual negotiated prices as well as copies of contract provisions between hospitals and health plans. The analysis focused on several markets throughout the

state, including the downstate area of New York City plus Suffolk and Westchester counties. The study found that the highest-priced hospitals are 50% to 170% more expensive than the lowest-priced hospitals in the same region, and that's on average across all of the different types of services that they offer. And as we've seen in other research, in which other people have pointed out, the study found that hospitals with higher prices do not necessarily have higher quality. Rather than quality, the primary factor driving high prices is market share. And general hospitals that are part of a hospital system with the larger market share were the highest-priced hospitals in their country or borough as a result of the power the hospital system has in contract negotiations. This was the case for most of the regions analyzed, including most parts of the greater New York City area, although Manhattan was an exception to this, as was noted earlier. The report also found certain contract provisions that impede healthcare competition and transparency for consumers. These include things like anti-steering language, which can limit the information available about high-quality, lower-priced providers. These

contract terms can compromise a patient's ability to seek out more affordable or better care options. One last finding I will discuss from this study, since the issue of cost shifting has come up earlier is that hospitals in the downstate region that serve more Medicare and Medicaid patients garner lower prices in the private commercial market. Moreover, hospitals that serve fewer Medicare and Medicaid patients garner higher prices in the commercial market. This pattern...

SERGEANT AT ARMS: Time expired.

MARK ZEZZA: ...contradicts a widely held belief that a hospital negotiates for higher commercial prices to offset lower reimbursements received through their publicly insured patients. In conclusion, the lack of transparency combined with high and variable prices is anti-consumer. It can lead to higher premiums, ah, higher healthcare taxes, and even higher prices for non-healthcare-related goods. Excessively high prices, especially when they come out as a surprise to a patient can also undermine the patient-provider relationship. The lack of transparency also undermines the ability of employers, patients, and other healthcare providers,

other healthcare purchasers, excuse me, to shop for more efficient health care. Thank you for your attention on this important topic, and I'm happy to answer any questions you may have.

MODERATOR: Thank you for your testimony. We will now turn to Raul Rivera. Ah, before I cue the next panelist I want to make an announcement that if we have inadvertently missed anyone that is registered to testify today and has yet to be called, please use the Zoom raise hand function now and you will be called on in the order that you raised, your hand has been raised, after our next panelist. So thank you and Raul Rivera, you may begin, once you are ready and once the sergeant cues you. Thanks.

SERGEANT AT ARMS: Time starts now.

RAUL RIVERA: Ah, good afternoon. My name is Raul Rivera. I'm a Bronx native. Ah, I'm a TLC driver. Ah, I won't be speaking about taxis today. But I'm also a, a certified nursing assistant. Ah, I'm not working as for now, but I've worked in the past. Um, I don't have anything written down. I do have some bullet points that I want to bring up, and I'm, I'm, I'm a little bit, ah, forgive me if I, if I get a little worked up, ah, I'm

really upset. I'm really upset about mandates, and we're talking about access to care and we're talking about hospital cost. There's no greater, ah, injustice to have our frontline workers, our nurses, people who work in the hospitals to be fired, to be forced to take a vaccine that they don't want. We, we have so many elected officials in this city. There's been many freedom rallies against, ah, forced mandates, and nobody is coming out to speak out or speak for, ah, the frontline workers. Um, there's, there's nothing more brave in, in doing what they did. It's, it's incredible the work that they did. Um, um, I'm really upset. I, I see a lot of hypocrisy, and, ah, if you're, if you're for abortion rights you should be against mandates, because it's my body, my choice. They go hand in hand. Nobody has autonomy over your body. Um, I'm trying to get, ah, Mr. Eric Adams to, ah, let me know what's his stance. We know that, ah, Cochair Levine is for mandates. Um, I think it's pretty, it's, it's disgusting, really. We, we, we call, we call these front-line workers heroes and today they're zeroes. They're being fired and nobody is speaking up for them. I hope I'm able to speak with the Council

Member, ah, Carlina Rivera, when you have some time so we can go over some more of my points. Ah, we need elected officials to speak up for the front-line workers. You have to speak up for them. You, you've been elected to speak for us. You're our elected officials. You need to speak for us. You got to defend our rights. I don't know if you guys are doctors, but you can't tell people what to do when it comes to their body. It's freedom over fear. My body, my choice, and we need to end the hypocrisy. We need to stop pandering to the voters. We need to protect our front-line workers. We're talking about access to care, we're talking about hospital costs. What's the cost of losing our workers? There will be no access to care if they continue to get fired. Thank you for your time.

SERGEANT AT ARMS: Time expired.

MODERATOR: Thank you for your testimony. Seeing no hands raised, um, we will now conclude this panel and I will turn it over to the chairs for closing remarks and statements, starting with Chair Rivera.

CHAIRPERSON RIVERA: Thank you so much. Ah, I will just say that health care is a human

right. This is not a debate. And access to affordable care, um, is non-negotiable. Um, earlier today we, we stood with the Coalition for Affordable Hospitals to demand fair hospital pricing because we believe that is the right thing to do for the well-being of all New Yorkers. So I want to thank everyone who testified today and, and gave, and, and shared their experiences, but also, um, really share their concerns and the, and the things that we have to do to make this a more equitable and transparent system. So I want to thank everyone from our, our state elected officials, our labor leaders, advocates, um, and all New Yorkers for, for taking some time to be with us today. And I'll turn it over to Cochair Levine before I close us out. All right. Well.

CHAIRPERSON LEVINE: Sorry about that. I was, ah, on mute there. Thank you, Chair Rivera. Ah, I'm in transit, so I'm gonna keep the camera off, apologies. Ah, before I make closing remarks I, I do, I can't let the statement of our final, ah, witness, ah, go without any response. Um, we make room for the public to speak here and, and Mr. Rivera, we welcome you taking that opportunity to

tell. You have the right in this country to, ah, refuse treatment for cancer, for a broken leg, ah, for a clogged artery, ah, for better for worse, if, ah, you don't want to take care of yourself for those, um, medical problems that's your right. But none of those conditions are contagious. None of those conditions will call someone, cause someone who's breathing your air to die. And as elected officials we have a moral obligation to save the lives of our constituents to prevent unnecessary death. That is what's on the line right now in this pandemic. It's why we mandate vaccines for a whole host of contagious diseases, ah, from polio to measles. And, and that has prevented incalculable suffering and saved millions of lives, lives here in New York City and elsewhere. And, ah, it's why we have no choice but to make sure that, ah, particularly and extremely high risk settings like hospitals that we protect first and foremost staff members, their families, and, and patients by ensuring that everyone, um, who works in those environments is, is vaccinated and there's, at this point there's, ah [inaudible]. All right, at this point there is strong evidence that these, these

mandates work because, ah, the vast majority of staff in hospitals now, um, ah, into the mid 90s percent has opted to get vaccinated, which was a great success. But just, just, ah, turning back to our topic today, my goodness, there was so much powerful testimony, um, ah, the last panel, ah, for sure, ah, I can't say how impressed I was by the information that all of you shared. Ah, I, I remain even more upset now than I was four hours ago. There's just no question that there are indefensible disparities in the prices being charged, charged New Yorkers for, ah, essential medical care and that's leading to costs that are so high that it's impacting workers, it's impacting unions, it's impacting, ah, our, our city's budget, and we can't accept it. It has to be fixed. Transparency is a big part of the solution. Um, and we're gonna stay on this, ah, with our allies at the state and at the federal level. So, thank you, Chair Rivera, really a pleasure to cochair this with you and I'm grateful for your leadership on this issue. Thanks again, and back to you.

CHAIRPERSON RIVERA: Thank you, Chair Levine, and I, I echo those sentiments on what we have to do, um, to make this a more transparent

process to be fair to all New Yorkers, especially those who, who truly need these services, and the glaring disparities across the city. And, and so with that I will, ah, adjourn this hearing. I thank you all for being here. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date November 8, 2021