New York City Council

Committee on Hospitals
Committee on Health

Hearing Testimony:
"Oversight: Rising Health Care Costs"

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GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Rivera, Chair Levine, and members of the Committees on Hospitals and Health, my name is Andrew Title, Assistant Vice President at the Greater New York Hospital Association (GNYHA). GNYHA proudly represents all the hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island. I appreciate the opportunity to speak with you today about health care costs and how they affect New Yorkers.

GNYHA believes health care is a human right and that everyone should have access to quality care. Both the government and the health care community have made great progress towards this goal. Millions more have coverage because of the Affordable Care Act (ACA), Medicaid expansion, and the Child Health Plus, Family Health Plus, and Essential Plan programs. GNYHA, in partnership with 1199SEIU United Healthcare Workers East, helped to develop and support many of these programs. As a result, the uninsured rate in New York State has been cut in half, to 5%[1]—about half the national average.

Despite these insurance coverage expansion successes, too many people across this City and country struggle to afford care, and GNYHA is committed to addressing that. Today, I hope to shed some light on this complex problem.

I will touch on four main topics: the challenges facing New York hospitals, factors that influence health care costs, state and national efforts to protect consumers from unexpected medical bills, and possible solutions.

A Time of Peril for New York Hospitals

New York's vital community hospitals face unprecedented threats to survival. Around 30 are on a statewide Department of Health (DOH) "watch list" for closure. These hospitals have less than 15 days cash on hand, and require regular, significant infusions of State dollars just to keep the lights on and meet payroll. There are watch list hospitals in the Bronx, Brooklyn, and Queens; [2] Manhattan and Staten Island also have severely challenged institutions. DOH has provided these hospitals with around $800 million in the current State fiscal year (FY).

Part of the reason these hospitals struggle is that they care for many Medicaid and Medicare beneficiaries and uninsured New Yorkers. Medicaid rates cover only 74% of the cost of caring for these patients,[3] meaning critical safety net hospitals lose money on almost every individual they treat; Medicare's payments are only slightly higher.

From 2008 to 2018—a full decade—New York State hospitals did not receive a single Medicaid rate increase as operating, labor, and supply costs such as pharmaceuticals steadily rose. Consequently, New York hospital margins are among the lowest in the country: the State average was only 1.8% in 2017,

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[1] However, around one million New Yorkers still lack care, and we have a plan to get them covered. We know that about a third of the uninsured are already eligible for Medicaid but not enrolled; a third are eligible to purchase private individual coverage through the State health exchange but find it unaffordable; and the remaining third are low-income undocumented immigrants who are not eligible for any form of subsidized coverage other than emergency Medicaid. GNYHA supports policies to expand access to care for each of these groups, including: streamlining Medicaid enrollment and renewal, campaigns to enroll individuals in public insurance programs for which they are eligible, State-funded tax credits to supplement available Federal tax credits so coverage is more affordable for individuals, and expanding the Essential Plan to wrap around emergency Medicaid for low-income undocumented immigrants (as proposed in A.5974/S.3900 and supported in Council resolution 0918-2019).

[2] New York City hospitals in the program include Brookdale Hospital, Jamaica Hospital, Flushing Hospital, St. John's Episcopal Hospital, Interfaith Medical Center, Kingsbrook Jewish Medical Center, and Wyckoff Heights Medical Center.

[3] GNYHA analysis of New York State Institutional Cost Reports, 2017.

compared to 5.9% nationally.[4] This severely limits these hospitals' ability to invest in facilities, equipment, and staff.

To stay afloat, hospitals must, if they can, negotiate higher rates with commercial insurers to cover their Medicare and Medicaid losses. But not all hospitals care for enough privately insured patients to achieve this "cost shift," which is the cause of the financial distress we have seen among our safety net hospitals.

In the FY 2018-19 State budget, 1199SEIU and GNYHA convinced Albany to increase Medicaid rates by 2%, but that relief for safety net hospitals is now in jeopardy. As has been widely reported, the Division of the Budget (DOB) estimates the FY 2020 Medicaid gap at $3 to $4 billion. Since 2013, the Legislature and Executive Branch have limited Medicaid spending growth to the rate of medical inflation, usually around 3% (the Medicaid "global cap"). Decreased Federal assistance, increased labor costs, and higher Medicaid enrollment have placed enormous strain on this artificial boundary.

Meanwhile, the Trump administration is doing everything it can to undermine urban hospitals, first by seeking to repeal the ACA without a replacement and now by refusing to defend the landmark law in court. Compounding the problem, cuts to the Medicaid Disproportionate Share Hospital (DSH) program—which supplies $3.5 billion annually to New York's public and voluntary safety net hospitals, in recognition of the uncompensated care they provide from treating the uninsured and Medicaid patients—are scheduled to go into effect on December 20.

Despite all these challenges, hospitals—unique among health care providers—are available 24 hours a day, 365 days a year. They save lives at every moment of every day, regardless of patients' ability to pay or insurance status. And as the largest non–public sector employer in the City, our hospitals are also the economic anchors of their communities.

Our public and voluntary hospitals serve huge numbers of Medicaid patients and provide the same high-quality of care to all. They have maintained major ambulatory care networks for many years that focus on providing care to the Medicaid patient population and other vulnerable New Yorkers, including the uninsured. In 2017, New York State hospitals provided over 8.5 million clinic and ambulatory care services to Medicaid and uninsured patients,[5] $3.4 billion in Medicaid services, $600 million in financial assistance, and $988 million in subsidized health services.[6] While for-profit hospitals are becoming the norm in other states, New York institutions continue to pursue their not-for-profit and public mission: caring for the most vulnerable.

What's Behind Rising Costs?

It is clear that health care costs are rising and much of the burden is falling on patients. This is especially true for those covered by commercial plans, who face higher insurance premiums, out-of-pocket costs, and prescription drug prices. (These costs also affect self-insured businesses and union benefit plans, which may or may not decide to pass increased costs onto beneficiaries.)

The Kaiser Family Foundation has compiled data on these trends. From 2009 to 2019, average annual premiums for family coverage topped $20,000, up from around $13,000. The worker contribution also rose

[4] New York margins: GNYHA analysis of New York State Institutional Cost Reports; U.S. margins: Medicare Payment Advisory Commission analysis of Medicare Cost Report data (December 2018).
[5] GNYHA analysis of New York State Institutional Cost Reports, 2017.
[6] Internal Revenue Service Form 990 reports.

during that period, from $3,515 to $6,015.[7] Deductibles rose 162%, far outpacing family premiums (54%), overall inflation (20%), and worker earnings (26%).[8] From 2006 to 2016, overall out-of-pocket spending "rose by 54%, from an average of $525 . . . to $806."[9] Unsurprisingly, more and more insured Americans say it is difficult to afford health care.[10]

There are many reasons why health care costs are rising. They include the state of the economy, medical inflation, insurance and pharmaceutical company business decisions, and local and Federal government policy. Provider and hospital practices (and the prices they lead to)—while important—are just one component of this dynamic.

Recently, many have focused on hospital sticker (or "charge master") prices, which hospitals are required to set. While these prices are important, the vast majority of patients at New York hospitals pay much less than these list prices. Similarly, commercial insurers and public insurance programs pay hospitals much less than those prices for the services they deliver to patients. This is because providers (including hospitals) and insurers *negotiate rates* for health care services that are typically much lower.

Here are some factors that contribute to what New Yorkers—and hospitals—pay for their health care.

Escalating insurer profits There is a huge mismatch between the size and scope of many of the insurance companies hospitals must negotiate with and the hospitals themselves. Our hospitals—all public or not-for-profit—negotiate with several behemoth, national, publicly traded insurance companies. Unlike our hospitals—which only serve their patients and communities—these corporations answer to their shareholders. They are hugely profitable, as evidenced by the latest numbers from the third quarter of 2019. UnitedHealthcare reported profits of $60.4 billion;[11] Anthem, Empire's parent, reported $1.2 billion in profits, up 23.2% from the same one last year;[12] and CVS, which now owns Aetna, reported $3.9 billion.[13]

These profits are larger than the entire annual budgets of many of our hospitals and health systems. Our hospitals' resources are a drop in the bucket compared to the resources of these for-profit companies, which have maximum incentive to pay the lowest possible prices so they can provide a return to their investors. They thus drive very hard bargains, and then engage in practices—such as payment denials for medically necessary services—to avoid or postpone payments to hospitals for as long as possible.

In this daily war against massive for-profit companies, New York's hospitals are overmatched, and fighting their payment denials and delays is an enormous administrative burden. Some health systems have entire departments dedicated to this task. Every hospital with any commercial patient base struggles with ongoing, massive unpaid debt for services already delivered to patients. As a result, New York's hospitals effectively

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[7] Kaiser Family Foundation, "2019 Employer Health Benefits Survey." https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/
[8] Ibid.
[9] Claxton, G., Levitt, L., Rae, M., Sawyer, B. "Increases in cost-sharing payments continue to outpace wage growth" Peterson-KFF Health System Tracker. June 15, 2018. https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/
[10] Ibid.
[11] UnitedHealth Group Reports Third Quarter 2019 Results. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2019/UNH-Q3-2019-Release.pdf
[12] Haefner, M. "Anthem's profits grow to $1.2b," Becker's Hospital Review. October 23, 2019. https://www.beckershospitalreview.com/payer-issues/anthem-s-profits-grow-to-1-2b.html
[13] CVS Health Reports Third Quarter Results. https://s2.q4cdn.com/447711729/files/doc_financials/quarterly/2019/q3/Q3-19-Earnings-Release.pdf

provide loans to highly profitable corporations. It's worth noting that a 2019 RAND Corporation study found that the prices private insurers in New York State pay hospitals are the third-lowest in the country.[14]

One of the most egregious examples of insurer bad behavior is issuing "admission denials" after a patient's hospital stay. By arguing (often dubiously) after the fact that care could have been given in an outpatient setting—insurance companies can cut around 70% of the total payment. Between 2006 and 2010 at one hospital, the admission denial rate rose 250%, reaching 2% of annual revenue—roughly the median hospital operating margin in New York State.

While comprehensive denials data can be difficult to find, independent analyses found that insurers on the national health exchange rejected one out of every five claims in 2017[15] and that private Medicare insurers "overturned 75 percent of their own denials during 2014–16."[16] Unfortunately, blanket denials are becoming a business model, with severe consequences for hospitals without the power to stand up to massive insurance companies.

Escalating drug prices. Hospitals have little to no control over the cost of the pharmaceuticals they need to deliver patient care. Like the insurance industry, drug companies reap massive profits year after year. From 2008 to 2016, according to the Petersen-Kaiser Family Foundation Health System tracker, the "costs of oral and injectable brand-name drugs increased annually by 9.2 percent and 15.1 percent," oral and injectable specialty drugs by "20.6 percent and 12.5 percent," and oral and injectable generics by "4.4 percent and 7.3 percent."[17]

Other costs Factors that also contribute to health care costs—for both hospitals and patients—include rising medical device costs, medical malpractice costs (the cost of liability insurance in New York is perennially among the highest in the nation), high cost-of-living, high labor costs, and proliferating government mandates (hospitals and health care in general are very highly regulated). While reasonable people can disagree on the causes of these conditions, there is no doubt that they ultimately contribute to higher health care costs for everyone.

Conclusion New York City's not-for-profit and public hospitals provide care to all New Yorkers of all income groups. They are there for all of us in emergency situations, no questions asked. They provide myriad unreimbursed or under-reimbursed benefits for their communities, including school-based health clinics; ambulatory care networks; training of physicians, nurses, physician assistants, pharmacists, and other health care professionals; cutting-edge research that leads to cures and saves countless lives; and investments in the latest health technology.

Unlike in other states, where most hospitals are not Medicaid providers, all of our hospitals provide high-quality medical care for Medicaid patients. Our city's hospital infrastructure benefits every New Yorker

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[14] W. Chapin and C. Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," RAND Corporation, p. 20. Available at https://www.rand.org/pubs/research_reports/RR3033.html.

[15] Henry J. Kaiser Family Foundation, "Analysis: Marketplace Plans Denied an Average of Nearly One in Five Claims in 2017 with Wide Variations across Insurers," February 25, 2019. Available at https://www.kff.org/private-insurance/press-release/analysis-marketplace-plans-denied-average-of-nearly-one-in-five-claims-in-2017-with-wide-variations-across-insurers/.

[16] U.S. Department of Health and Human Services Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials," September 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[17] Cox, C., Kamal, R. "Recent trends in prescription drug spending, and what to look out for in coming years." Peterson-KFF Health System Tracker. December 9, 2015. https://www.healthsystemtracker.org/brief/recent-trends-in-prescription-drug-spending-and-what-to-look-out-for-in-coming-years/

and demands our protection. Hospitals provide these benefits to the people of New York City and more. Do insurance companies do the same?

Protecting New Yorkers from Surprise Bills

When patients with commercial (or employer-provided) insurance get care, they shouldn't be left with huge unexpected bills because they technically left their insurer's provider network. Thankfully, New York State has one of the most comprehensive laws in the country protecting individuals from these "surprise bills." These bills occur when patients, through no fault of their own, receive care from out-of-network providers in emergency situations or when they access care at an in-network hospital but are treated by out-of-network physicians.

GNYHA has long supported protecting patients from high out-of-pocket costs in surprise bill situations. We worked closely with legislators and State officials on the enactment of New York State's landmark "out of network" (OON) legislation, which took effect in 2015. The law guarantees that when patients need emergency out-of-network treatment, insurers cannot charge them more out-of-pocket than what they would have paid at an in-network provider. It also established a dispute resolution process for physicians and insurers if they failed to agree on payment.

In addition to emergency situations, the OON law applies when consumers make efforts to plan ahead and only use in-network providers, yet still get an out-of-network bill. The OON law has effectively taken consumers out of a process that was causing severe financial harm. A 2019 Department of Financial Services study called the law a resounding success, reporting that from its inception in 2015 through 2018, the OON law "saved consumers over $400,000,000," "reduced OON billing in New York by 34%," and "lowered in-network emergency physician prices by 9%."[18]

This year, New York Governor Andrew Cuomo signed legislation amending the OON law. Most notably, it brings hospitals into the dispute resolution process, which previously only applied to physician payments. It also requires that in these situations, insurers must pay hospitals at least 125% of the previous in-network rate and exempts certain safety net hospitals. GNYHA had significant concerns with the original version of this legislation because it would have increased the already considerable leverage national, for-profit insurance companies have when negotiating with New York's not-for-profit and public hospitals. However, we were able to work with stakeholders to revise the bill to limit the harm to hospitals, ensure that employers and insurers are not subject to unreasonable out-of-network charges and, of course, continue to protect consumers in surprise bill situations.

While New York's OON law is a great achievement, it only applies to state-regulated plans—not those established under the federal Employee Retirement Income Security Act (ERISA). These insurance products commonly cover people employed by large, self-insured companies or under union benefit plans. At least partly as a result, Congress is presently debating various plans to extend similar protections to these Americans. GNYHA fully supports enactment of Federal legislation to protect consumers from surprise bills and is working closely with elected officials in Washington to shape the legislation in a way that does not substantially harm hospitals.

GNYHA and many other health care groups believe that as the first state to adopt comprehensive, effective surprise billing legislation, Washington should follow the "New York model." The basic principles are as follows: hold patients harmless from surprise bills; don't preempt state laws that address surprise bills (as long as they protect patients); and create a dispute resolution process similar to New York's, rather than one that relies on arbitrary benchmark payment rates. We believe models that propose payment for surprise

[18] Department of Financial Services, "Report on the Independent Dispute Resolution Process," September 2019, p. 2.

bills at median in-network rates would give for-profit insurance companies even more power over local hospitals and result in diminished provider networks, limiting patient access to the doctors and hospitals they want to see. We will continue to work with Congress to pass legislation that fully protects consumers but does not give insurers undue leverage in contract negotiations or create incentives for insurers to offer more limited provider networks.

Hold Profit-Motivated Insurers, Big Pharma Accountable

Addressing rising health care costs requires us to look at the big picture. The best place to start is bringing the insurance and pharmaceutical industries in line, which reap record profits without regard for the best interests of patients.

Insurance People are rightly upset with insurance companies for high copays and deductibles, denials of medically necessary care, acres of red tape, sudden limits to provider networks, cancelling contracts with trusted physicians and hospitals, and absurd prior authorization practices. GNYHA supports changes to State and Federal law to rein in these abuses, including bills requiring that insurers simplify their rules and procedures, pay interest on overturned denials, and simplify overly complex administrative procedures.

GNYHA supports policies to help people afford their insurance by improving the ACA. These include increasing exchange subsidies, restoring so-called cost-sharing reduction funding to help individuals afford premiums, restoring the individual mandate, fixing the "family glitch" and coverage gap, rescinding negative Trump administration ACA actions, funding outreach and education, and creating insurer risk protections and high-risk pools. (Most of these would require Federal action, although some could be addressed at the State level.)

Pharmaceuticals Similarly, bad actors in the pharmaceutical industry have exploited vulnerable people that depend on their lifesaving drugs. One of the most publicized examples is the spectacularly priced Sovaldi, produced by Gilead Sciences, which treats Hepatitis C and was at one point priced at $168,000 per course of treatment. But drug companies have also raised prices for therapies that have existed for years, like insulin, or simply refused to produce critical products in sufficient quantities (like saline) because their expected profit is too small, resulting in shortages for patients and crises for hospitals. It's time for Congress to allow the Federal government to use its purchasing power to negotiate drug prices with manufacturers on behalf of Medicare beneficiaries, which it is currently prohibited from doing, and take other steps to bring pharmaceutical costs under control.

Hospitals Hospitals are committed to doing their part to lower health care costs for patients through a host of quality initiatives designed to reduce hospitalizations, emergency room use, and readmissions. Starting in 2011, New York State, under Governor Cuomo's leadership, initiated major Medicaid reforms designed to improve quality and efficiency, with a major emphasis on care management for all Medicaid beneficiaries. Later, as part of the State's Delivery System Reform Incentive Payment (DSRIP) program, hospitals and other providers created large collaborative groups known as Performing Provider Systems (PPS).[19] Nearly all of the hospitals in New York City participate in DSRIP, whose goal is to fundamentally restructure the health care delivery system and reduce avoidable hospital use by 25% over five years.

GNYHA and its members also recognize that the bills New Yorkers receive from hospitals can be confusing and stressful. This is partly because hospital billing departments have to deal with a multiplicity of insurance companies and plans, each with their own payment policies, and have no way of knowing what (or even whether) these insurance companies will pay for services that hospitals have already delivered to patients.

[19] See https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm.

Most important, we realize that we can always do better, and that's why we're working with our members to improve the billing process and make sure consumers better understand their options and obligations, including hospital financial assistance policies. GNYHA also supports legislation that would ban hospitals from sending out-of-network bills directly to consumers—other than the amounts they would owe if they had been treated by an in-network hospital—if they assign benefits to providers (S.9077 of 2018). The bill would also ban "balance billing" of the patient by the hospital.

Thank you for the opportunity to provide testimony on this important issue. I am happy to answer any questions.

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Testimony for Oversight Hearing: Rising Health Care Costs

December 12, 2019

Submitted by:
Community Service Society of New York

The Community Service Society of New York (CSS) would like to thank the Chair and members of the New York City Council Committee on Health for the opportunity to submit this testimony on rising health care costs. CSS is a 175-year-old 501(c)(3) non-profit dedicated to fighting poverty and strengthening New York. It seeks to address economic disparity through research, advocacy, and innovative programs that strengthen and benefit all New Yorkers. CSS recognizes that access to quality affordable health care is essential to building strong, equitable, and economically secure communities. Annually, its health programs help New Yorkers enroll into health insurance coverage, find healthcare if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the healthcare system. We do this through a live-answer helpline and through our partnerships with over 50 community-based organizations throughout New York State. Annually, CSS and its partners serve over 150,000 New Yorkers, saving them over $10 million dollars in health care costs. For more information on CSS, visit us on the web at www.cssny.org.

Under the Affordable Care Act, New York has cut the number of uninsured people in half since 2010. Despite this remarkable feat, there are still over 1 million uninsured New Yorkers. And study after study confirms what New Yorkers experience every day – rising health care costs and the diminishing value of coverage result in profound affordability problems even for consumers with insurance.

For example, CSS worked with Altarum's Healthcare Value Hub to do a survey on health care affordability in New York.[1] The results—even after New York's remarkable implementation of the Affordable Care Act—are sobering. New York City residents experienced even higher health care cost burdens than residents of other regions of the state. More than half (59%) of New York City residents surveyed (nearly all of whom were insured) said they had faced a health care affordability problem, such as cutting pills, not filling prescriptions, skipping care, or not doing what their doctor told them to do because of costs.

- 46% said they were struggling to pay medical bills: using up their savings; skipping meals or paying rent; or reported being in collections or having credit card debt.
- 71% worried about health insurance becoming too expensive.
- 65% worried about the cost of a serious illness or accident.
- 67% worried about health costs when elderly.[2]

In another consumer survey, one-third of respondents said they had paid bills they did not owe.[3] The reasons they gave for paying bills they might not owe included: the bills were too confusing, they did not think they could win against providers, and they were afraid not paying would ruin their credit score.

While national health care spending has slowed down,[4] New Yorkers experience a very different story. In 2008, New Yorkers were spending 5.5% of their median household income on health care. In 2016, that percentage increased to 7.7%.[5] At the same time, hospital bills are rapidly increasing. One study found that hospital prices grew 42% between 2007 and 2014, while doctor prices grew 18%.[6] While the hospital industry suggests that hospital consolidation will

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[1] Altarum Healthcare Value Hub, "New Yorkers Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines," Data Brief No. 37, March 2019, https://www.healthcarevaluehub.org/advocate-resources/publications/new-yorkers-struggle-afford-high-healthcare-costs-support-range-government-solutions-across-party-lines/.

[2] Altarum Healthcare Value Hub, "New York City Boroughs: 59% of Adults Experienced Healthcare Affordability Burdens in the Past Year," Data Brief No. 38, March 2019, https://www.healthcarevaluehub.org/advocate-resources/publications/new-york-city-boroughs-59-adults-experienced-healthcare-affordability-burdens-past-year.

[3] Penelope Wang, "Sick of Confusing Medical Bills?" Consumer Reports, August 1, 2018, https://www.consumerreports.org/medical-billing/sick-of-confusing-medical-bills/.

[4] Micah Hartman, Anne B. Martin, Joseph Benson, Aaron Catlin, and the National Health Expenditure Accounts Team, "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," Health Affairs, Vol. 39, No. 1 (January 2020).

[5] NYSHealth Foundation, "The Rising Cost Burden of Employer-Sponsored Insurance," March 2018, https://nyshealthfoundation.org/wp-content/uploads/2018/03/rising-cost-burden-employer-sponsored-insurance-NY.pdf.

[6] Zack Cooper, Stuart Craig, Martin Gaynor, Nir J. Harish, Harlan M. Krumholz, and John Van Reenen, "Hospital Prices Grew Substantially Faster Than Physician Prices for Hospital-Based Care in 2007–14," Health Affairs Vol. 38, No. 2, February 2019.

increase efficiency and lower prices, studies show that it actually results in higher prices.[7] Provider price increases are the main driver of growing health care costs in New York – especially inpatient prices, which grew twice as much in New York (32%) than nationally (16%).[8] These price increases occurred during a period when *actual inpatient utilization declined by 2 percent*. Of all of New York's health care stakeholders, individual consumers are the least able to accommodate these high prices, but consumers have little to no access to the cost and quality information that would allow them to shop for better deals.

Over time, the value of insurance coverage has declined. In an effort to keep employee contributions steady as premium prices rise, employers have increasingly chosen plans with larger cost-sharing requirements (e.g. deductibles and co-pays). The average annual deductible for consumers with employer-sponsored coverage that included a deductible rose 36% over the last 5 years and 100% over the last 10 years.[9] In New York, the average deductible for an employer-sponsored single-person insurance plan more than doubled between 2008 and 2018 ($732 to $1,554).[10] The average employee cost for premiums and deductibles in New York rose 65% from 2008 to 2018, from $3,935 to $6,471.[11] Despite increases in cost-sharing, the national average premium for employer-sponsored family coverage has risen 22% in the last five years; this increase is significantly higher than the increase in inflation or workers' wages during this period.[12]

New Yorkers blame the health care industry for the rising and out-of-control costs: 69% said that insurance companies charge too much; 69% said hospitals charge too much; and 68%

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[7] Cory Capps and David Dranove, "Hospital Consolidation And Negotiated PPO Prices," Health Affairs Vol. 23, No. 2, March/April 2004, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.23.2.175; Reed Abelson, "When Hospitals Merge to Save Money, Patients Often Pay More," New York Times, Nov. 14, 2018, https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html.

[8] Health Care Cost Institute and New York State Health Foundation, "Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York," July 2019, available at https://nyshealthfoundation.org/2019/07/30/health-care-spending-in-new-york-growing-faster-than-rest-of-u-s/.

[9] Kaiser Family Foundation, "Employer Health Benefits Survey 2019 Summary of Findings," September 2019, https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/.

[10] Commonwealth Fund, Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, "Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families," Table 4, November 2019, https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.

[11] Commonwealth Fund, Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, "Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families," Table 5, November 2019, https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.

[12] Kaiser Family Foundation, "Employer Health Benefits Survey 2019 Summary of Findings," September 2019, https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/.

said that drug companies charge too much. Seventy-two percent of New Yorkers agreed that "the U.S. health care system needs to change."[13]

New York has taken important steps to protect consumers with considerable success. For example, "surprise" medical bills were a top complaint to New York's insurance regulators, the Attorney General's Health Care Bureau, and our CHA Helpline. With the enactment of the 2015 New York Surprise bill law, many of these problems abated, because disputes mostly hold consumers harmless, leaving the providers and carriers to resolve them before an independent dispute resolution process.

The NYS Department of Financial Services, which implements the surprise billing protections, reports that the law "has saved New Yorkers more than $400 million in emergency services alone, reduced out-of-network billing in New York by 34%, and lowered in-network emergency physician payments by 9%."[14] A CSS analysis of cases in which Community Health Advocates (CHA), New York's designated health consumer assistance program, helped consumers with surprise bills found that they had favorable outcomes in 68% of cases. New legislation, signed by Governor Cuomo in October, will strengthen the law by subjecting hospital emergency room services, which were left out of the original legislation, to the independent dispute resolution process.[15]

While this an important first step, one loophole in the law remains. Over 30% of our consumers with surprise bills come to us because either the carrier or the provider incorrectly told the consumer that they were in-network, when in fact they were not. This is a serious problem because many hospitals fail to require their "attending" providers to take the same insurance as they do, resulting in consumers being billed for out-of-network providers.

As the surprise billing law example shows, there is much that New York City and New York State can do to protect consumers from the problem of rising health care costs. CSS, and our partners in the Health Care For All New York coalition, support a range of solutions that fit roughly into three buckets: (1) expanding coverage; (2) ending medical billing abuses; and (3) expanding health care consumer assistance and advocacy. CSS urges the Committee members to support these policies.

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[13] Altarum Healthcare Value Hub, "New Yorkers Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines," Data Brief No. 37, March 2019.
[14] "Winning the fight against surprise medical bills," Linda Lacewell, Superintendent of the New York State Department of Financial Services, New York Daily News, October 1, 2019, https://www.nydailynews.com/opinion/ny-oped-winning-the-fight-against-surprise-medical-bills-20191001-aoyalydhmncmjhn23tpyujmrxm-story.html.
[15] A264B/S3171.

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Expanding coverage

CSS strongly supports the New York Health Act (NYHA) because it would not only cover the remaining 1 million uninsured New Yorkers, but also eliminate the profound affordability problem and medical billing problems that plague nearly everyone else. A single-payer system that covers all residents through taxes, with no payment at point of service, would alleviate both problems.

If the NYHA does not pass or cannot be implemented by 2021, New York should comprehensively expand existing programs to meet New Yorkers' immediate needs. The vast majority of the remaining uninsured fall into three groups of people: (1) low-income adult immigrants who are ineligible for coverage (250,000 people); (2) moderate-income individuals who find coverage unaffordable despite the available subsidies (310,000 people); and (3) very low-income people who are eligible for Medicaid and/or Child Health Plus, but remain unenrolled (450,000 people).

To address these three groups of uninsured, CSS urges the enactment of the following measures:

1. Adopt S.3900/A.5974, sponsored by Assemblymember Gottfried and Senator Rivera, which creates a state-funded Essential Plan for immigrants who are ineligible for coverage. This program would be offered to the 250,000 unauthorized immigrants below 200% of the federal poverty level and would cost around $300 million in the first year.[16]

2. Make coverage more affordable for people. New York should establish additional state subsidies for people between 200% and 400% of the federal poverty level. California, Massachusetts and Vermont all have a state premium assistance program. This option would make coverage more affordable for approximately 155,000 New Yorkers and cost anywhere between $270 million and $550 million, depending on the generosity of the subsidies.

3. Support more community-based enrollment assistance to reach the hard-to-reach eligible but uninsured. New York's current Navigator program is funded at $27.2 million, but these

[16] E. Benjamin, "How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents? An Analysis of Three Coverage Options," January 2016, https://www.cssny.org/publications/entry/covering-new-yorks-uninsured-immigrant-residents. A less costly option, detailed in the same report, would be to adopt S8618/A.8054 which provides coverage to young adult immigrants. This option would cover nearly 30,000 people at a cost of $83 million. (Cost estimates updated by the author).

community-based Navigators have not had a pay raise, or cost-of-living increase, in over six years. The City Council or State Legislature should consider supplementing these funds, with an extra emphasis on communities that have a disproportionate percentage of the remaining uninsured—like New York City.

Ending unfair medical billing

Similarly, there are important measures that can help people address the affordability and medical debt crisis. Assemblymember Gottfried and Senator Rivera, Senator Breslin, and Senator Krueger introduced A.8639/S.6757, the Patient Medical Debt Protection Act, which addresses the medical debt crisis by implementing the following measures. These measures require all the stakeholders to come together and adopt a patient-centered approach to health care costs and medical billing that address *patients'* needs.

1. Make patient billing simple. Consumers are bombarded by bewildering bills from myriad providers operating out of a hospital. Example: Chandak G. went to the hospital for a kidney stone and got 27 different bills from the emergency room, radiologist, and many others. One hospital visit should result in one NYS-created uniform, standardized, itemized hospital bill that explains each charge and is sent within seven days of discharge.[17]

2. While medical providers only have two years under state law to submit insurance claims, they can sue patients for up to six years after the service was provided.[18] Example: A patient was sued over five years after his hospital stay: his bill totaled almost $25,000, including nearly $7,000 in interest. That's not fair. Fifteen other states have a shorter statute of limitations than New York.[19] For example, Arkansas imposes a statute of limitations of only two years for medical debt.[20] Medical debt should have a two-year statute of limitations and the statutory interest rate should be cut from 9% to 3%.

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[17] New York's current Patient Bill of Rights requires that hospitals provide patients with an itemized bill and explanation of charges on request, but this is rarely offered. 10 N.Y.C.R.R. §405.7(a)(16).
[18] N.Y. C.P.L.R. §213 (McKinney 2018).
[19] Those states include: Alaska (A.S. 09.10.053), Arkansas (Ark. Code Ann. §16-56-106), California (C.C.P. §337), Colorado (C.R.S. 13-80-101), Delaware (Title 10, § 8106 (a)), Florida (F.S. 95.11 (2)(a)), Idaho (Title 5, Ch. 2, 5-26), Kansas (Ch. 60, Article 5, Section 11 (1)), Maryland (Commercial Law §2-725), Mississippi (MCA § 15-1-29 and 15-1-49), Nebraska (Neb. Rev. Stat. §25-205), North Carolina (§ 1-52), Oklahoma (O.S. § 95(1)), South Carolina (SCCLA 15-3-530), and Texas (C.P.R. §16.004(a)(3)).
[20] Ark. Code Ann. §16-56-106.

3. New York's 2015 surprise bill law[21] was a landmark consumer protection, but it is missing a key piece: surprise bills caused by provider or plan misinformation. A survey of more than 200 Community Health Advocates' surprise bill cases found that 35% resulted from misinformation provided by either the plan or the provider.[22] Example: Claudia K. scheduled what she thought was an in-network visit because her provider directory told her the doctor was in-network, and she was stuck with a $101,000 bill. New York's law leaves consumers on the hook for those bills. Plans are already required to update their provider directories within 15 days of a change but rarely do.[23] Consumers should be held harmless if given false information about their provider network.

4. Patients are charged for hospital overhead, through charges called "facility fees." Example: Sintora S. went in for a mammogram, expecting to be charged a co-pay, but then received a surprise $149 facility fee. Connecticut has already banned many facility fees for outpatient services provided off-campus and required robust disclosures to patients about the use of facility fees.[24] Consumers should not be responsible for so-called "facility fees" that are not actual medical services.

5. There is no uniform hospital financial assistance form, forcing financially needy patients to jump through hoops to get the discounts they need. Each hospital has a different form and process, many of which violate the state law and guidance. New York's hospital financial assistance law[25] should:
   - Apply to all providers working in a hospital even if not employed by the hospital as well as charges for ambulance and other pre-emergency services.
   - Require one standard application to be used at each hospital.
   - Require one standard appeal process.

6. Providers ask patients to sign patient financial liability forms that waive patients' state

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[21] NY Financial Services Law Article 6.
[22] E. Benjamin and E. Webb, New York Surprise Bill Law: The consumer perspective and ongoing challenges, presented to the New York State Health Foundation October 29, 2018.
[23] NY INS L §3217-a(a)(17) and §4324(a)(17).
[24] Connecticut General Assembly, Sec. 19a-508c. Connecticut defines facility fees as "any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is (A) intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee" (Sec . 19a-508c(3)), and defines hospital-based facility as "a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided."
[25] NYS PBH § 2807-k 9-a.

protections against liability for medical bills, without even knowing what those may be. Example: Susan received a surprise $280 bill from a hospital-based out-of-network lab. The hospital told her that she was responsible for the bill because she signed a waiver. She found the waiver language in fine print on the patient information and medical history form she signed when she went for the blood draw. All hospitals should be required to use one uniform hospital financial form.

7. New York seeks to establish a consumer-friendly website, the All Payer Database, to control costs and provide patients the cost and quality information they need to make informed choices. Some hospitals claim that insurance companies cannot report their cost data, saying it's "proprietary." Licensed providers in New York should be required to provide complete information—regardless of payor or "proprietary pricing contracts" —to the All Payer Database as a condition of operating and in a way that makes the information accessible to consumers.

Health care consumer assistance

Finally, New York State and New York City can expand access to health care consumer assistance and advocacy services. CSS supports Council Member Rivera's proposal to create an Office of the Patient Advocate. The Office of the Patient Advocate would provide patients with important resources, as well as collecting data that would help New York City and New York State better regulate our City's non-profit hospitals.

For example, the Patient Advocate could get a better handle on the hospitals'—which receive generous City tax exemptions—debt collection practices, including disclosing:

- the number of patients they have sued;
- the number of patients' homes they have placed liens on;
- the number of wage garnishments they have executed against patients;
- the amount of interest and fees they have received as a result of these lawsuits; and
- the amount of financial assistance they have actually provided to New York City residents.

CSS also lauds the City Council for its support of the MCCAP and Access NYC programs, which fund outreach, education, and one-on-one consumer assistance to New York City residents who need help enrolling in insurance, using insurance, or finding sources of free or discounted care.

Thank you for the opportunity to submit this testimony. Should you have any further questions, please do not hesitate to contact Elisabeth Benjamin at ebenamin@cssny.org.

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District Council 37 AFSCME AFL-CIO

Testimony of Henry Garrido
Executive Director, District Council 37, AFSCME
Before the Committee on Health and Committee on Hospitals
Re: Rising Health Care Costs
December 12, 2019

Good morning Chairs Levine, Rivera and fellow Committee members. My name is Henry Garrido and I am Executive Director of District Council 37, which represents 300,000 New Yorkers who are covered by health insurance and live in the NYC metropolitan area. I want to thank you both for holding this important hearing to discuss the rising cost of health care and hospitalization.

I appear before you today to identify some of the reasons health care costs have skyrocketed the last decade – and to suggest a few ways to bring this unsustainable situation under control.

The single factor that has had the most profound, negative impact on healthcare coverage in New York City is the cost of in-patient (and out-patient) care provided by the City's non-profit, voluntary hospitals.

At the outset, I'd like to point out that District Council 37 and our brother and sister unions that make up the Municipal Labor Committee are doing our part to reduce hospital bills with changes in the design of our health plans.

For example:

- We have moved non-urgent, but essential procedures from hospitals to outpatient centers (e.g., colonoscopies, infusions);
- We have changed our insurers' co-pay structures to discourage members from utilizing Emergency Rooms for non-urgent treatment;
- We have implemented wellness programs, diabetes disease prevention programs, and telehealth programs to improve our members' health and prevent hospitalizations.
- We have looked for and implemented every way to change our members' conduct to rely upon hospitals for their primary care and lower costs.

But New York City's non-profit, private hospital systems are not doing their part to contain costs.

The largest five hospital systems that dominate NYC still find ways to increase their costs by 7-8-10 percent each year, year after year after year. These costs are then passed on to us employers, participants and labor organizations that provide health care to NYC's working families.

Why do they do it? Because they can.

And they are enabled by the complexity of contracts between the insurer and hospital. These contracts create discrepancies that are incomprehensible:

- A hip replacement procedure can cost $83,000 at one hospital and $56,000 at another.
- Hospitals that serve Medicare and Medicaid patients receive lower prices in the private market, while hospitals that serve insured patients have higher prices.
- On average, higher-priced hospitals in the NY metro area are 2.5 times higher than the lowest-priced hospitals.

It is not necessarily true that higher costs translate into the best quality of care.

Research shows NYC's public hospitals provide higher-than-average quality care, even though they are increasingly picking up the costs of treating populations that private hospitals do not. As you all know, NYC Health + Hospitals is charged with treating patients regardless of their ability to pay.

And just because non-profit, private hospitals charge higher rates does not necessarily mean their patients receive better treatment.

Just this week Governor Cuomo called upon the State Department of Health to investigate the terrible overcrowding and understaffing at Mt. Sinai's emergency room.

The former head of the Emergency department went on the record to say: "Mount Sinai wins top national rankings for such specialty departments as pediatrics, oncology and elective surgery. Do its administrators just figure that the kind of patients who show for the ER just aren't worth much

trouble, because the hospital's all too likely to lose money on treating them?"[1]

Adding insult to injury is the fact that hospital executive compensation has soared along with the cost of care.

In 2018 Crain's New York Business reported that the top 10 highest paid hospital CEOs received combined salaries, perks and other compensation totaling more than $53 million.

At the same time, the city and state also offer hundreds of millions of dollars in tax breaks.

Currently, there are 655 tax exempt properties owned by non-profit, private healthcare facilities totaling $1.177 billion. This figure includes the $106 million in tax exemptions for NYU and Columbia Presbyterian.

If these non-profit hospitals are enjoying year after year of surpluses, do they need to be receiving tax breaks AND hiking costs?

Finally, in the last decade, we have seen hospital consolidations resulting in the creation of five NYC area mammoth health systems. These networks are creating monopolies which also only adversely impact patient costs.

What can be done about this? I would like to offer four recommendations:

I. Conduct an investigation into these private hospitals with high cost services that decline to treat uninsured and under insured, low-income and immigrant populations.
II. The City, along with the State, must re-evaluate its property tax exemptions to private hospital systems that are not willing to treat populations that can least afford their services.
III. Create a stakeholder group that includes labor unions, health care advocates, consumers, healthcare institutions and insurance providers to discuss the cost and quality of health care.
IV. The City Council should monitor all hospitals (private and public) and health plans to measure disparities in pricing and care.

Thank you.

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[1] Post Editorial Board, *Does Mt. Sinai want its emergency room to be a horror?* (New York Post December 9, 2019)

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Planned Parenthood of New York City

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Testimony of Planned Parenthood of New York City
Before the New York City Committee on Health
Regarding Rising Healthcare Costs

December 12, 2019

Good morning, my name is Naysha Diaz and I am a Government Relations Associate at Planned Parenthood of New York City. I would like to thank Committee Chair Council Member Mark Levine for holding this important oversight hearing on the rising costs of healthcare in New York City.

Planned Parenthood of New York City (PPNYC) has been a leading provider of sexual and reproductive health services in New York City for more than 100 years, conducting over 90,000 patient visits per year. PPNYC provides a wide range of health services including access to birth control; emergency contraception; gynecological care; cervical and breast cancer screenings; colposcopies; male sexual health exams; testing, counseling, and treatment for sexually transmitted infections; the HPV vaccine; HIV testing and counseling; and pregnancy testing, options counseling and abortion. We also provide PrEP and PEP, transgender hormone therapy, vasectomies, and menopausal hormonal therapy. We are a trusted name in health care because of our commitment to comprehensive, inclusive care.

In the U.S., health care costs have continued to rise for all parties including employers, individuals, and medical providers. The Kaiser Family Foundation found that 5% or 1,006,900 of New York state residents were uninsured in 2018.[1] According to the Mayor's Management Report of 2019, 11.6% of adult NYC residents were uninsured in 2018.[2] The NYC Department of Health reported that in 2015, 1% of New York City children were uninsured.[3] In New York City, as of 2019 11% of Queens residents were uninsured, 9% of Bronx residents were uninsured, 9% of Brooklyn was uninsured, 6% of Manhattan was uninsured and 5% of Staten Island was uninsured.[4] As a result, many people, especially in New York City, rely on safety net providers that offer financial help or sliding scale fees like PPNYC, community health centers and Health + Hospitals. PPNYC provides all services regardless of an individual's ability to pay. Additionally, we have financial counselors who meet with patients to help determine if they are eligible for health insurance such as Medicaid, Child Health Plus, the Family Planning Benefit

[1] https://www.kff.org/other/state-indicator/total-population/?dataView=1&activeTab=graph&currentTimeframe=0&startTimeframe=10&selectedDistributions=uninsured&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] Fuleihan, D. & Thamkittikasem, J. (2019). Mayor's Management Report. Retrieved from https://www1.nyc.gov/assets/operations/downloads/pdf/mmr2019/2019_mmr.pdf

[3] NYC Health. (2019). Health Care Access and Use: NYC Child Health Data. Retrieved from https://a816-health.nyc.gov/hdi/epiquery/visualizations?PageType=ts&PopulationSource=CHS&Topic=2&Subtopic=15

[4] https://www.countyhealthrankings.org/app/new-york/2019/compare/snapshot?counties=36_005%2B36_047%2B36_081%2B36_061%2B36_085

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Program, or through the New York State of Health Marketplace. In 2018, PPNYC was able to help 6,666 patients obtain health insurance. In 2018, 62% of PPNYC patients were insured by Medicaid, paid reduced rates, or received free sexual and reproductive health services. It is no surprise that PPNYC has seen an increase in the number of patient visits. In 2014, PPNYC conducted 84,159 patient visits, and in 2018, we had an increase to 91,409 patient visits.

Federal action has also contributed to rising health care costs. This year, the Trump-Pence administration implemented a gag rule for all providers who participate in the Title X Family Planning Program. The gag rule prohibits health care providers who receive Title X funding from refering patients to safe and legal abortion, among other agregious restrictions. As a , PPNYC and other health care providers were forced to withdraw from Title X. However, 150,000 New York City residents relied on Title X funding. This gag rule disproportionately affects immigrants with lower incomes who rely on Title X to access health care services, since many aren't eligible for health insurance.[5] PPNYC is grateful that New York State implemented emergency funding, but the supplemental funding is a temporary solution to a long-term problem. So while PPNYC and many other former Title X recipients will remain open to anyone who walks through our door, it is not without a cost to health care providers.

Costs for many of our patients enrolled in private insurance have also increased. Nationally, the amount employers and employees have paid on health care premiums and other out-of-pocket expenses have significantly increased over the past 10 years. The Kaiser Family Foundation found that on a national level the amount that employees contribute to their health care premiums has increased 62%, while employer contribution has also increased by 48%, from 2009 to 2019.[6] This places a heavy burden on individuals, families, and employers. According to UnitedHealth Group, between 2013 and 2017, hospital prices have risen 17%, while physicians' prices have risen 10%, and patients' utilization has declined by 5%.[7] In our health centers, we have noticed that certain health services are not covered by insurance, making it a burden for our health centers and patients. For instance, some insurance companies don't cover the HPV vaccine, which protects people from cervical cancer and more. We also have noticed that patients are not signing up for qualified health plans or are not able to use the coverage they have because they can't afford the deductibles. These patients end up paying out of pocket for their health care services or receiving sliding scale services, depending on their health care provider.

At PPNYC we know how crucial it is for patients to be able to access health care. New Yorkers face many barriers in seeking preventive care, including the rising cost of medical services. PPNYC applauds the City Council for its efforts to address this. We urge you to continue to help lower the costs of health care, especially for communities with the least access.

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[5] Tapales, A., Douglas-Hall, A., & Whitehead, H. (2018). The Sexual and Reproductive Health of Foreign Born Women in the United States. *Guttmacher Institute,* 47-51.

[6] Kaiser Family Foundation. (2019). Retrieved from http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019

[7] United Health Group. (2019). Confronting the High Cost of Hospital Prices. Retrieved from https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/Hospital-Prices-Drive-Inpatient-Spending.pdf

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PPNYC will continue to advocate and support bills like Res. No. 918, which calls on the New York State Legislature to pass and the Governor to sign A.5974/S.3900. This law would establish a state-funded Essential Plan and allow more individuals to enroll in a public health insurance plan, regardless of their immigration status. PPNYC also continues to support Intro. 1668 and the creation of a Health Access Program. This bill would expand access to health care services at Health + Hospital facilities, non-for-profit and private medical providers, regardless of immigration status, employment status or preexisting conditions. We look forward to continuing to work with the City Council and we are hopeful that collectively, we can make our city healthier and more affordable for all. Thank you.

###

Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of sexual and reproductive health services and education for New Yorkers. Through a clinical services, education, and advocacy, PPNYC is bringing better health and more fulfilling lives to each new generation of New Yorkers. As a voice for sexual and reproductive health equity, PPNYC supports legislation and policies to ensure that all New Yorkers will have access to the full range of sexual and reproductive health care services and information

Testimony of the New York Health Plan Association

to the

New York City Council Committee on Health
on the subject of

Rising Health Care Costs

December 12, 2019

Chairman Levine and members of the committee, thank you for the opportunity to appear at this week's hearing on Rising Health Care Costs.

The New York Health Plan Association is a non-profit organization that represents 29 health plans that provide coverage to nearly eight million fully-insured New Yorkers. The people served by HPA's member plans include individuals who receive coverage through an employer or who purchase it on their own directly through a health plan or through the NY State of Health, the state's Exchange, and residents covered by state programs including Medicaid, Child Health Plus, the Essential Plan and Managed Long-Term Care.

Our member health plans are committed to the goal of universal coverage, and have a long history of working collaboratively with New York government in implementing the Affordable Care Act and the state's ambitious Medicaid redesign program. This common effort is a major reason for New York's success in insuring coverage for more than 95 percent of state residents and reducing the number of uninsured from 10 percent in 2013 to less than five percent today.

Keeping health care affordable is *the* number one challenge facing all of us in the health care system, and rising costs remains the most pressing health care issue facing employers and consumers. According to the recent annual report by the CMS Office of the Actuary, nationally per capita spending on health care increased by four (4) percent in 2018, up from 3.5 percent in 2017, as faster growth in medical prices more than offset slower growth in the use and intensity of health care goods and services.

New York has some of the highest health care costs in the country, and markedly higher than the national average. In their July 2019 report, *Health Care Spending, Prices and Utilization for Employer-Sponsored Insurance in New York*, the NY State Health Foundation and the Health Care Cost Institute (HCCI) noted that "spending is increasing at a rapid rate and rising price, not greater utilization of services, is the main culprit." As the report noted, "These data point to prices of services that experienced particularly high growth, including for certain inpatient admissions and prescription drugs, as areas of focus for New York employers, health plans, and State policymakers to target in efforts to control health care costs for their employees."

Health insurance premiums reflect the cost of care. While every New Yorker deserves access to high-quality care, making that a reality requires addressing the underlying factors driving health care costs. Among them:

- Provider Price Growth Driven in Part by Continued Consolidation;
- Increases in Prescription Drug Prices; and
- Government Taxes, Fees and Assessments.

Provider Price Growth and Provider Consolidation

The wave of mergers, acquisitions and clinical affiliations among hospitals, physicians and other providers will reshape the health care system for years to come. Some have suggested the changes in the delivery system are necessary and will result in better integration and improved quality for patients. However, there is a growing body of research among policy experts that greater provider consolidation does not, in fact, lead to better care and lower prices, but rather merely leads to enhanced bargaining power for providers with no notable improvement in quality of care for patients.

Government can take steps to promote greater accountability of these provider transactions, provide increased transparency of provider costs, and restrict contracting practices that harm consumers and employers. Additionally, government can take measures to protect consumers from excessive charges by prohibiting providers from imposing unnecessary "add-on" costs. Approaches should include:

- **Enhanced oversight of provider mergers, acquisitions and affiliations:** Update the state's Certificate of Need process to require annual reporting of entities that merge and that they hold their prices flat for a 3-5 year period, to ensure that benefits described for the transaction are actually realized and that employers and consumers benefit from lower costs and better quality.
- **Eliminate Certain Contracting Practices:** Prohibit restrictive contracting language that serves as a barrier to promoting greater competition in the marketplace, increasing transparency of health care costs, and providing more affordable options for employers and consumers. Measures should include:
    - prohibiting "all-or-nothing" clauses in which an insurer is required to contract with all provider locations for a multi-location provider instead of contracting only with individual provider locations;
    - allowing for contracting with individual institutions based on quality measures;
    - barring confidentiality clauses that limit the ability of consumers to know prices charged by providers;
    - forbidding anti-steering provisions that prohibit insurers from using benefit design to encourage consumers to obtain care at more affordable provider sites; and
    - disallowing provisions that limit the ability of health plans or employers to offer tiered network products if they do not include certain hospitals in the most favorable tier.
- **Ban hospital facility fees:** Prohibit hospitals from imposing facility fees for services provided in a hospital or at a facility not on a hospital's campus.

Increases in Prescription Drug Prices

While advances in the development of life-saving medications offer tremendous clinical benefits for patients, rising prescription drug prices is a major threat to keeping health care affordable for employers and consumers. At the same time, it is unclear these price increases are justified.

An October report by the Institute for Clinical and Economic Review (ICER) examined whether certain price increases are justified by new clinical evidence or other factors. An independent, non-partisan research organization that objectively evaluates the clinical and economic value of prescription drugs, medical tests, and other health care and health care delivery innovations, ICER analyzed pharmaceutical manufacturer price increases on seven widely used drugs in 2017 and 2018. The examination found the price hikes resulted in an additional $5.1 billion in spending for insurers and consumers. **Its analysis asked the question, "Was there any new clinical evidence to support those price increases?" Their conclusion: No.**

Breakthrough medications should not be a blank check. Out-of-pocket costs are dictated by the list price of a drug, which is solely determined by the drug manufacturer. As consumers, employers, providers, health plans, and the state grapple with rising prescription drug costs, greater understanding is needed into how prescription drug prices are set and the rationale for price increases. Approaches should include:

- **Price Transparency:** Consumers, employers, state government programs, providers and health plans must price and budget many months in advance, leaving the health care delivery system vulnerable to uncertainty regarding price changes for existing drugs and the prices of new drugs. Considering the role that pharmaceutical costs have on health care spending, sensible measures should be taken requiring pharmaceutical manufacturers to explain the prices they charge for the product. This should include state reporting on how often the price of the drug has increased and the rationale for the increases, the direct costs associated with manufacturing the drug, such as R&D and materials costs, marketing and distribution spending, net profits, spending on patient assistance programs and coupons, and other important clinical details that may affect the price of the drug.
- **Early Warning of Price Increases:** Unfortunately, as prices on new medications go up, it has also resulted in the rising price of existing prescription drugs and treatments that are already in the marketplace. There is little to no information provided by manufacturers to justify these substantial increases in the price of the prescription drug. Prior to any prescription drug price increase of more than 10 percent of the wholesale acquisition cost (WAC), including cumulative increases that occurred within the previous two calendar years, the manufacturer should provide 60 days' notice of the increase. The notice should require the manufacturer to disclose simple and easy producible information such as the date of the increase, current WAC of the prescription drug, the dollar amount of the future increase in the WAC of the prescription drug, and an explanation on the need for the

increase so that consumers, employers, providers, health plans, and the state have notice before the increase takes effect.

Government Taxes, Fees and Assessments.

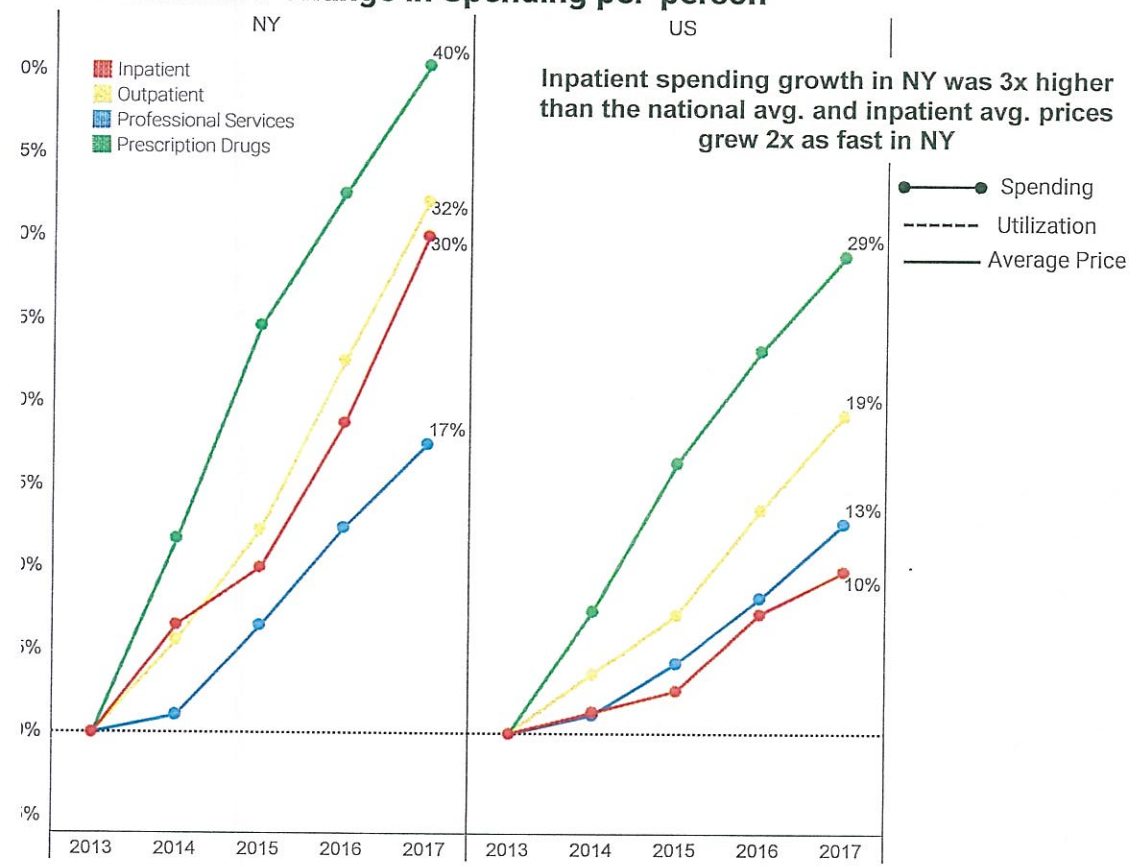
The cost of government taxes adds to the cost of coverage for New Yorkers. The state collects nearly $5 billion annually through Health Care Reform Act (HCRA) patient services assessment, which a tax on inpatient and outpatient hospital charges as well as numerous other health care services ($3.8B), and covered lives assessment, a sales tax placed on every policy sold in New York State ($1.1B). The HCRA taxes representing the third largest source of state revenue behind the sales and income taxes. Other state taxes and fees on health insurance include a 1.75 percent premium tax on commercial health insurance policies that is directed to the general fund and Section 206 "assessments" totaling $271 million in this year's budget that fund the Department of Financial Services' operations.

Further, while the Affordable Care Act (ACA) has had a significant impact on expanding coverage for millions of New Yorkers, taxes associated with the ACA are also making the cost of health care coverage more expensive for employers and consumers. For example, the ACA established an annual fee on health plans – the so-called Health Insurance Tax – that is a direct sales tax on health insurance. While Congress has imposed a moratorium on this tax, the moratorium expires at the end of this year, which will result in an additional $1 billion in costs for New York in 2020. Currently, bipartisan legislation to extend the current moratorium through 2021 is pending in Congress and we would urge you to encourage the state's Congressional delegation to support this important bill.

Again, we appreciate the opportunity to offer our comments and are happy to engage in further discussions with the Council.

Addressing Underlying Costs

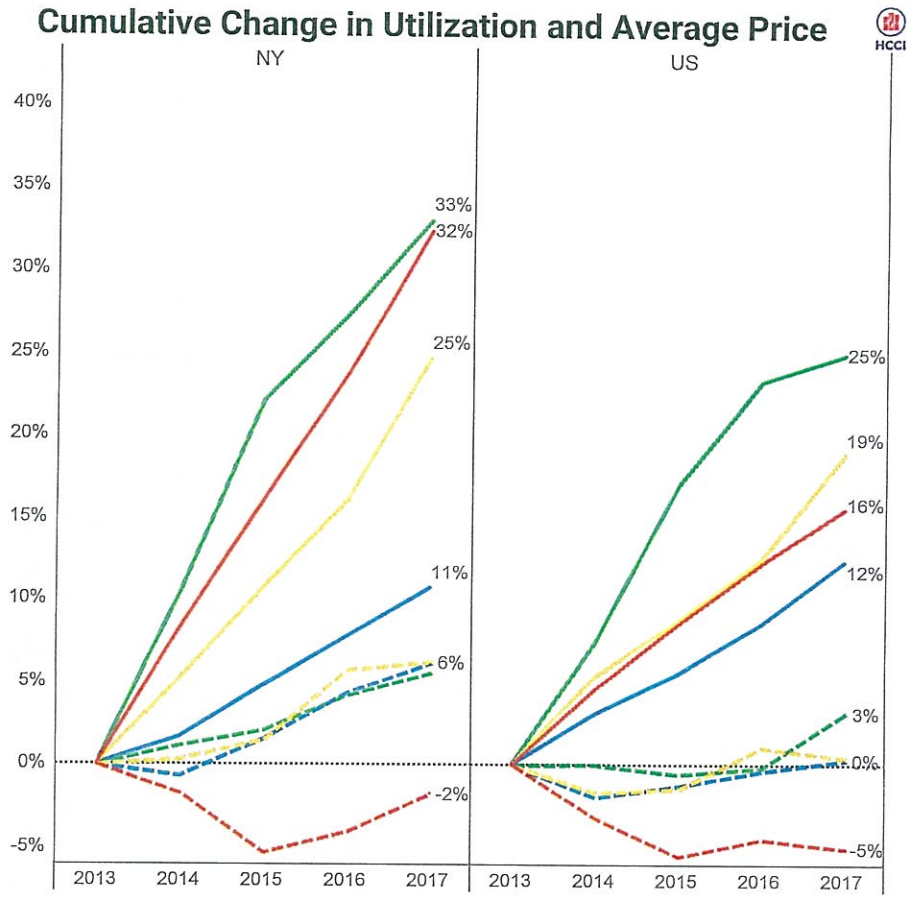
Cumulative Change in Spending per-person



Inpatient spending growth in NY was 3x higher than the national avg. and inpatient avg. prices grew 2x as fast in NY

Spending
Utilization
Average Price

Cumulative Change in Utilization and Average Price



source: Health Care Cost Institute & NY State Health Foundation, *Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York*, July 2019

Addressing Underlying Costs

FIGURE 5: New York Spending Per Person by Type of Service in 2017

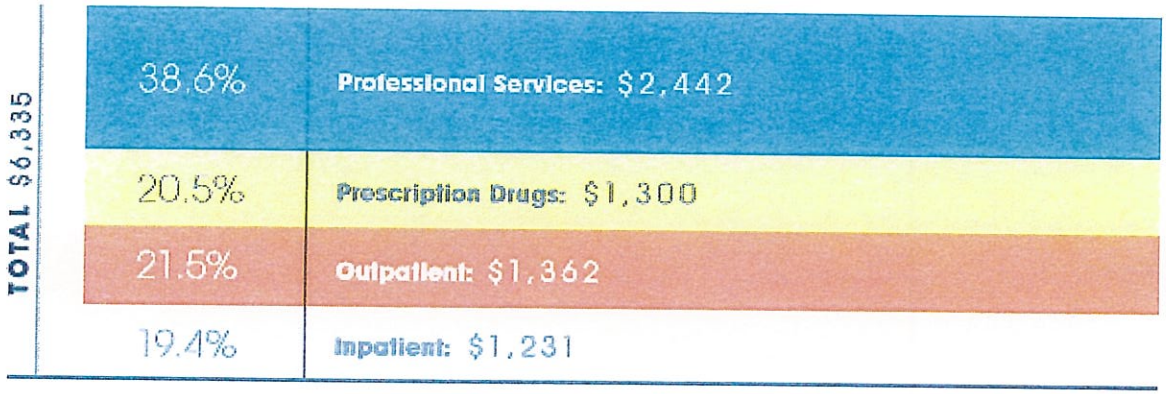
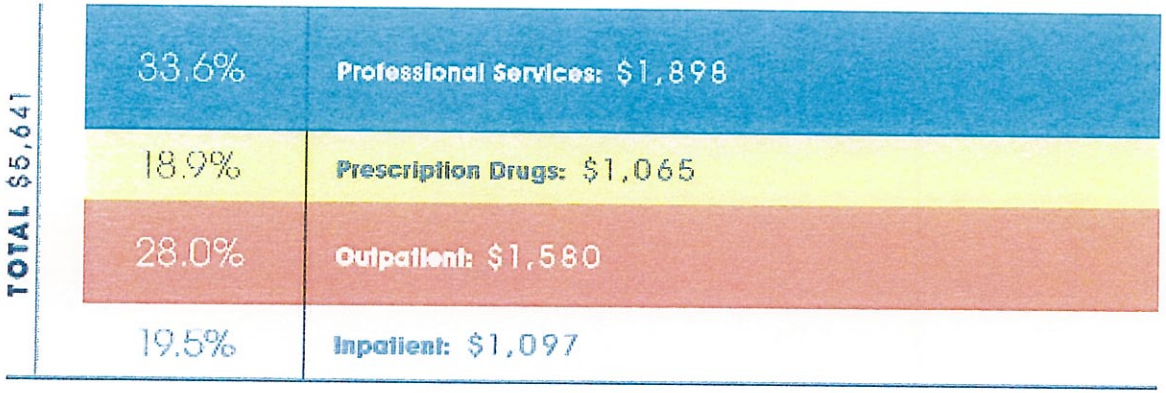


FIGURE 6: National Spending Per Person by Type of Service in 2017

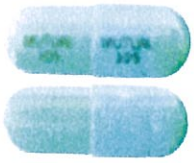


source: Health Care Cost Institute & NY State Health Foundation, *Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York*, July 2019

Addressing Underlying Costs

Then and Now

The Cost of Prescription Drugs

	AWP 2011	Increase	AWP 2018
Benicar  Used to treat high blood pressure	$3.10	142%	 $7.50
Doxycycline  Used to treat bacterial infections	$0.96	595%	 $6.67
Enbrel  Used to treat autoimmune diseases	$451.32	175%	 $1,242
EpiPen  Used to treat severe allergic reactions	$90.07	214%	 $282.41
Humira  Used to treat arthritis, plaque psoriasis, Crohn's disease, and ulcerative colitis	$1,006.19	142%	 $2,436

Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

www.32bjfunds.org
212-388-2000

Testimony
December 12, 2019

Good morning committee chairs Levine and Rivera and good morning committee members. Thank you for your time this morning and for your attention to the important issue of rising health care costs. My name is Sara Rothstein. I am the Director of the 32BJ Health Fund, a multiemployer plan that provides benefits to union members of SEIU 32BJ and their eligible dependents.

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

Our Fund is self-insured, which means that the Fund, not an insurer pays for all medical claims incurred by our members. We design the benefits – what is covered and what the out of pocket costs are. We use a Third Party Administrator (Empire BlueCross BlueShield) to provide a network and adjudicate claims. We get claims data, so we know where people go for care and what we pay each time they use their benefits.

Our members pay no premiums and no deductible for in-network care and we offer a choice of providers in a large network, with no or low copays for preferred providers, higher copays for other providers.

We spend more than $1 billion each year on hospital medical costs. So we have been using our claims data to understand why healthcare is so expensive in NYC. We have found that one of the major drivers is the high cost of out of network care.

Sometimes a member will see an out of network doctor on a planned basis, but members are often treated by out of network doctors in the emergency room or when they are admitted to the hospital for emergencies or go for a planned admission – like childbirth – and are unknowingly treated by doctors who are out of network. Members go to in-network hospitals thinking that the doctors will all take the same insurance as the hospital.

When a doctor is out of network, there is no pre-negotiated rate for payment and doctors can bill as much as they want.

The 32BJ Health Fund protects members from surprise bills from out of network doctors but the high costs of these bills threatens the stability of the Fund.

It's not just a problem for the 32BJ Health Fund. The Northeast Business Group on Health represents purchasers in New York City and beyond. Members include union health and welfare funds like ourselves, the City of New York and many corporate employers. The group recently conducted a survey of its members about surprise billing and 40% of employer respondents said surprise bills are a significant problem for their employees.

When the 32BJ Health Fund reviewed provider claims from 2016-2018 for care that was provided at a hospital, we identified Northwell Health as the health system:

- Having the most dollars paid to out of network providers
- Having the most claims from out of network providers
- Having bills from the highest number of out of network providers

The 32BJ Health Fund paid over $4 million dollars to out of network providers who provided care at Northwell's 18 hospitals in New York, most of which are in downstate NY. This is more than the total amount that the 32BJ Health Fund paid to out of network providers at any other health system in downstate New York. And 13% of dollars paid by the 32BJ Health Fund to providers at Northwell hospitals were for OON bills, more than at any other health system

I'd like to give you an example of a surprise bill from an out of network doctor at one of Northwell's hospitals. An out of network cardiologist at a Northwell Hospital interpreted the results of a heart test for a patient who was admitted to the hospital. This provider billed $4,950 for interpreting the test results. The 32BJ Health Fund identified 128 claims from 2017 for in-hospital services in the same county, with the same billing code and modifier as the claim from the out of network doctor. The in-network providers who provided those same services were paid an average of $83. The 32BJ Health Fund also identified 223 claims from in-network providers who provided the same service at a Northwell hospital and the 32BJ Health Fund paid those Northwell in-network providers an average of $120 for the same service.

There are four Northwell hospitals in New York City: Lenox Hill Hospital; Long Island Jewish Forest Hills; Long Island Jewish Medical Center; and Manhattan Eye, Ear and Throat.

These fees are driving up the cost of health care for New Yorkers, and unlike our members, many people have to pay part or all of these bills themselves if their insurance provider won't.

There are ways to keep costs under control. The Council should require hospitals with physical locations in NYC to disclose:

- What insurance and benefits networks each hospital accepts
- The total number of doctors with credentials at each hospital
- And the total number of doctors at each hospital who accept the insurance and benefits networks that the hospital accepts

PRIMARY CARE DEVELOPMENT CORPORATION

pcdc.org

Testimony for
New York City Council Health Committee and Hospitals Committee
Joint Oversight Hearing on Rising Health Care Costs

December 12, 2019

Thank you to the City Council and committee chairs, Council Member Mark Levine and Council Member Carlina Rivera, for today's oversight hearing on rising health care costs and for the opportunity to share our recommendations. I am Patrick Kwan, Senior Director for Advocacy and Communications for the Primary Care Development Corporation (PCDC).

Founded in 1993 by Mayor David Dinkins and a visionary group of health and civic leaders, PCDC is a nonprofit organization and a U.S. Treasury-certified community development financial institution that has partnered with the City of New York for over 25 years to build equity and excellence in primary care for millions of New Yorkers. PCDC has worked with over 400 health care sites to increase and improve the delivery of primary care and other vital health services across all five boroughs. We have financed and enhanced health care facilities and practices in 50 out of 51 City Council districts, including financing half of all Federally Qualified Health Centers (FQHCs) – from the smallest to the largest — in New York City. And through our capacity building programs, PCDC has trained and coached more than 9,000 health workers to deliver superior patient-centered care, including at NYC Health + Hospitals, where we have provided technical assistance for ambulatory care redesign for more than 15 years.

Our mission is to create healthier and more equitable communities by providing the capital, advocacy, research, and expertise needed to build, expand, and strengthen our primary care infrastructure. We believe every New Yorker in every neighborhood should have access to high-quality primary care.

Rising Health Care Costs Are Threatening the American Dream and Impoverishing the Impoverished

The unsustainable and untenable rising costs in medical expenditures – including health insurance premiums, co-pays and deductibles for provider visits and prescription drugs, as well as the cost of medical services that are not covered by insurance – are threatening the American dream of upward mobility for families and children, as well as their opportunity for prosperity and success. Too many hardworking families and individuals are just one medical bill, a hospital stay, or an emergency room visit away from a financial nightmare that threatens their economic stability.

New Yorkers are right to be worried about access to affordable health care and affordable housing – high costs of both health care and housing can drive people into bankruptcy and onto the streets, and both health care and housing are needed for families and individuals to pursue their careers and education, as well as their prosperity and stability. A Kaiser Family Foundation study released earlier this year found a large majority (67%) of Americans are worried about being able to afford surprise medical bills for them and their family. More than half (53%) were very worried or somewhat worried about affording their health insurance deductible, 45% about prescription drug costs, 42% about monthly health insurance premium, 41% about rent or mortgage, and 37% about food.

Every year, rising health care costs take a bigger bite out of the bottom line of workers and their families and have erased all the average worker's wage increases – and more. Health insurance premiums, for example, continues to rise more quickly than workers' wages and inflation over time; since 2009, average family premiums have increased 54% and workers' contribution have increased 71%, several times more quickly than wages (26%) and inflation (20%).

As this year's New York City Government Poverty Measure found, medical expenses can pull New Yorkers into poverty. Of the elements that raise the NYCgov poverty rate, medical expenses have the highest effect. In the absence of medical expenditures, the city's poverty rate of 19% would be 2.9 percentage points lower, or 16.1 percent.

Medical expenses pushed more than 7 million Americans into poverty or in deeper poverty according to a 2018 national study conducted by researchers from CUNY – Hunter College, Harvard Medical School, and the Boise Veterans Affairs Medical Center. These families and individuals spent about a third or more of all their income on health care. Of the 7 million, more than half – 4 million – were pushed into the ranks of extreme poverty, where their post-health care income reduced below 50 percent of the poverty line and they spend about two-thirds of all their income on health care.

Health Care Affordability and Accessibility

Affordability is a critical component of access to health care. The availability of providers and services to a patient is only relevant if the patient can also afford the cost of the care. Half of U.S. adults say they or a family member put off or skipped some sort of health care or dental care or relied on an alternative treatment in the past year because of the cost, and many say their medical condition got worse as a result. Adults who are in worse health struggle more with care affordability; 19% of adults reporting worse overall health also reported that they delayed care or forewent care at times due to cost, whereas 7% of adults in good health reported delaying or forgoing treatment due to cost. Uninsured adults were also more likely to delay or forego care due to cost compared to their insured counterparts (28% vs. 7% respectively).

Higher levels of comprehensive care with primary care physicians has been associated with lower Medicare costs and hospitalizations. Conversely, higher spending is not associated with better outcomes; the U.S. has some of the worst outcomes in terms of life expectancy at birth, infant mortality, and primary care quality.

Nationally, areas with higher primary care investment also have better patient outcomes. Similarly, in New York City, communities with better access to primary care have better indicators of health. Access to care in NYC varies significantly by Council District – in District 2 in Manhattan there are 64 primary care providers per 10,000 constituents but only 1.7 PCPs per 10,000 in District 34 in Brooklyn. Further, while many Districts have insured rates of over 90%, District 21 in Queens has 40% uninsured residents. The percentage of PCPs who accept Medicaid and Medicare also vary, impacting whether patients with public insurance can see providers in their District. This council district-by-council district analysis to examine primary care access across the city was made possible through a generous discretionary award from the City Council. We are extremely thankful to the City Council, Speaker Johnson, and the many members of the Committees on Health and Hospitals for your continued support.

Building a Bridge to Better Health and Lower Costs Through Primary Care

Rising health care costs are coupled with rising calls for health system reform. Considering the complexity of the U.S. health care system and issues of inequity and inequality, it may seem that nothing can be done. Yet studies have found there are strategies for fixing the health system. Front of mind to many are controlling drug costs and minimizing the costs of middlemen, and less apparent is prioritizing primary care.

New Yorkers need hospital beds for when we are seriously sick and emergency rooms for emergencies — and, most of all, we need primary care services to stay healthy, maintain our health from infancy to old age, and avoid costly hospital stays and emergency room visits. PCDC firmly believes that without primary care, families risk illness that can threaten their well-being and financial security as well as worsen health, social, and economic inequities. Studies show that

primary care can bend the health care cost curve – but investments in primary care must go up before total cost of care goes down.

At PCDC, we recognize that the entire premise of health system reform rests on a robust, high-quality, and universally accessible primary care system. The evidence is clear: more primary care leads to better outcomes, better community health status, and reduced cost. Along with provider and patient satisfaction, these are the critical elements of a successful health reform approach by government, payers, health systems, and providers.

Primary care is the foundation for integrating the full spectrum of health and social services to improve health outcomes and the key to sustainable, accessible, and equitable health systems. It is a cornerstone of healthy, thriving communities and helps keep families healthy, children ready to learn, and adults able to pursue their careers.

Primary care is not the solution to every health issue but there are few chronic health conditions that can be managed better without primary care.

That is why PCDC strongly supports the investments and commitments made in recent years by the City Council, NYC Health + Hospitals, the Department of Health and Mental Hygiene (DOHMH), and the de Blasio administration to enhance and expand access to primary care, including through funding for DOHMH's Prevention and Primary Care program's Bureau of Primary Care Access and Planning (PCAP) and Bureau of Primary Care Information Project (PCIP) as well as through initiatives such as Caring Neighborhoods, One New York: Health Care for Our Neighborhoods transformation plan for H+H, and most recently, the establishment of NYC Care and its expansion to include FQHCs and other not-for-profit and private medical service providers.

The City and H+H's commitment to build new primary care centers in Manhattan, Queens, Brooklyn and Staten Island, as well as expanding services at existing primary care sites in the Bronx, Brooklyn and Queens are critically important. This, along with the Caring Neighborhoods support for non-H+H facilities – in which PCDC has been a financing partner with the City – has already brought significant new primary care capacity to communities. This is a long-lasting legacy to improve the health of poorer communities in New York City, and one which we applaud.

PCDC encourages the City Council to explore additional opportunities to promote primary care by:

Maximizing City Council Grant Funds for Additional Primary Care Expansion

PCDC has been a strong and willing partner to the City across administrations. As a U.S. Treasury-certified community development financial institution with a mission-driven expertise in financing community-based health care, PCDC has found the most success in leveraging our resources to partner with the City and other entities, jointly financing projects for community primary care providers without recourse to bank capital. The strategy is to finance the construction, expansion, and renovation of facilities and programs through a variety of capital instruments, including public and private loans, debt, and grants. This enables the financing of key projects and ensures that scarce public resources are matched with private dollars to finance more and larger projects, all to meet the immediate and substantial needs in our communities. In addition to our technical assistance capacity, we have a variety of financing mechanisms and technical assistance available to support new or renovated primary care facilities.

Our recent financing in New York City for projects such as Apicha Community Health Center in Lower Manhattan, Callen-Lorde Community Health Center in Downtown Brooklyn, the Institute for Community Living and Community Healthcare Network's East New York Health Hub, and the Joseph P. Addabbo Family Health Center in the Rockaways have included

federal New Markets Tax Credits, New York State Community Health Care Revolving Capital Fund, and private investments in addition to City Council grants. We look forward to working with the City Council on a comprehensive strategy to maximize grant funds for financing primary care infrastructure expansion and improvement needs in our communities.

Investing in FQHCs

New York City's nonprofit community-based Federally Qualified Health Centers provide quality primary care and other vital health services to 1.2 million patients, regardless of their ability to pay or their health insurance or immigration status. The City Council's continued investment with discretionary funding for FQHCs will ensure their ability to sustain programs and services to serve all New Yorkers in need of high-quality, comprehensive care.

Supporting Primary Care and Behavioral Health Integration

There is a substantial need for supporting primary care and behavioral health integration. Patients with serious mental illness are often affected by chronic medical conditions. Just as it is important to integrate behavioral health into primary care settings, we must also integrate primary care into behavioral health settings to help prevent and reduce chronic conditions and promote wellness of New Yorkers.

Developing a Primary Care Plan for New York City

PCDC recommends the development of a comprehensive citywide plan to create a stronger, more sustainable and connected primary care system. Plan components could seek to address fundamentals such as the assessment of citywide primary care capacity, performance, and needs; how primary care workforce recruitment and transformation can be supported; and capital and financing needs for facility and program expansion and sustainability.

With overwhelming evidence of its positive impact on improving health care quality and outcomes while lowering health care costs, primary care is the most reliable means of ensuring patient and community health. To meet its responsibility, primary care must be reinforced with sound policies and adequate resources. We look forward to working with the City Council to support these goals.

Thank you for your consideration of our recommendations to help build and strengthen New York City's primary care infrastructure to help address rising health care costs and their effect on New York's families.

Contact:

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Primary Care Development Corporation
45 Broadway, 5th Floor, New York, NY 10006
(212) 437-3927 | pkwan@pcdc.org

cphs*

*putting the public back in public health

New York City Council – October 31, 2019

Health Committee Hearing

Oversight - Rising Health Care Costs

Testimony from Anthony Feliciano, Director of the Commission on the Public's Health System

Good Morning,

My name is Anthony Feliciano. I am the Director of a citywide health advocacy organization called the Commission on the Public's Health System. Thank you for this opportunity to testify today on a very critical topic that is part high cost of health care to individuals and families and high spending from government on delivery that care.

CPHS is a voice for the public health and hospital system, a voice for the allocation of public funding in the state and city budgets; a strong supporter of community organizing, and supporter of the health care safety net and access to health care services for everyone, particularly in low-income, medically underserved, immigrant and communities of color.

I had some challenges writing on this topic not because there is not enough data and information about it, but simply because there are so many factors and areas for focus. Health insurance costs are going up because of two main factors: The increasing costs of doctors, hospitals, and drugs, Federal policies, including uncertainty regarding "risk adjustment" payments and the growing threat to repeal of the Individual Mandate. However, they are other highly major issues that play a major role around rising health care costs.

1. A health care system influence by political and institutional interests like the health insurance industry that cares less about people and more about profits
2. No real comprehensive health planning to address New Yorkers getting sicker, especially low-income, immigrant, communities of color, people with disabilities and other marginalized populations

Frankly dental insurance isn't really insurance. It's a maintenance plan that will cover cleanings and x-rays, maybe half the cost of a crown. It will not protect you if you need a lot of work done. The maximum annual benefits, $1,000 to $1,500, haven't changed in the 50 years since dental insurance became available.

Anywhere from 60% to 80% of what a patient pays goes toward the expense of running a modern dental practice We have a widening divide between patients' expectations of their dental insurance coverage and the actual coverage that's provided.

<u>High cost of prescription drugs</u>

Prescription drug poll by Kaiser showed that 35% of those taking 4 or more prescription drugs say they have a difficult time affording prescription medication. (February 2019). 27% of Americans — or 1 in 4 — say they take four or more prescription drugs. (October 2019). 29% say they did not take prescription medication as directed because of the cost. (February 2019)

When you look at New York, spending on prescription drug medications outpaced the national average by 20% during the same period. Per-person spending across all prescription drug categories in New York was $1,300 in 2017 compared to $1,095 nationally. More surprising nearly 85%, were generic medications, but such medications accounted for just 22% of all prescription drug spending in 2017. That means most prescription drug costs rising still are from name brand drugs.

<u>Overhead</u>

A substantial percentage off the insurance premiums paid by employers or individuals are for marketing and administration. Another percentage is for profits. Under Obama-care the portion of the premium going to marketing, administration and profits was constrained to 20 percent for small insurers and to 15 percent for large insurers. Basically, higher spending also translates to higher out-of-pocket and premium costs for consumers

Every health reform that emerges including the New York State Medicaid Waiver program vastly complicates the system further and brings forth new fleets of consultants who make a good living assisting health care systems on how to cope with the reforms. All their income becomes the providers' expense and thus ends up in the patient's bill.

State Resource Allocations

New York is recognized as a state with progressive leanings and rich diversity, yet historically and continually sustain the racial and economic inequities that hinder real health care reform and transformation that would lead to healthier and well communities. While they are more areas to help reduce costs. I like to focus on two.

1. DSRIP and future Medicaid Waiver Programs

Our healthcare system has reflected the inequities in its overall structure and delivery of care. New York State recognized that the health care delivery deficiencies were connected to the rising cost of health care because of overuse of the ER, non-clinical factors such as social determinants of health, and how hospitals were being reimburse for that care. To address this, they invested $8 billion dollars to restructure its health care system by instituting the Delivery System Reform Incentive Payment (DSRIP) program. Again, the funding went primarily to hospitals, which was one of the first mistakes. The second mistake was not building in the community-based organization (CBOs) in an equally positioned strategic way. An important resource in this coordinated effort are community-based organizations that handle the outreach, non-clinical service delivery and tailor it to the unique needs and circumstances of the areas they serve and engage. Combined integrated approaches to outreach and ensuring assistance to accessing health care services improves access, quality and reduce costs.

Now the state is embarking on an extension and renewal of their Medicaid Waiver. This next stage could be pivotal in assisting lowering what New York State spends on health care, while not compromising access and quality.

2. Indigent Care Pool

NY's current way of distributing charity care funds places the future receipt of hundreds of millions of DSH dollars in jeopardy. The current method is not in line with federal law. Without DSH dollars, public hospitals that provide care to many uninsured and Medicaid patients will be forced to make drastic cuts in their services and staffing. The loss of these dollars may result in the closure of private safety-net hospitals, which will leave medically underserved communities without access to health care services and exacerbate health care disparities. The state's health care providers already spend nearly $130 million/year in uncompensated care for uninsured people, most prominently NYC H+H. However, money and politics play calamitous roles in determining

where money under the ICP (Indigent Care Pool or Charity Care) funding is directed. This has created an unfair and unequal allocation of ICP to hospitals who do not play a real safety-net health care role for underserved communities. Due to the vulnerable population's safety-net hospitals serve, these hospitals are at a greater risk of reducing services and/or closing from the accumulation and unequal distribution of uncompensated care costs. This also could translate in higher costs in spending in delivery of health care, passing the costs to patients, and decrease access to vital health care services for the most vulnerable which in turns makes it more costly for the system.

Recommendations:

- NYS must capitalize on the strengths of its infrastructure while enabling change and engaging new allies to better address this issue and not solely consultants and insurance industry.
- Support raising taxes on the ultra-wealthy and the big corporations doing business in our state. They can afford to pay their fair share and ensure social and health programs are not slashed because in the end it will contribute to rising health care costs.
- Price transparency in health care is needed: accurate, easy-to-understand, meaningful information about what consumers can expect to pay for their care
- Make The state's Department of Financial Services more accountable to New York residents and not to the industry, which is tasked with monitoring health care costs in New York. Particularly useful areas of focus for New York employers, health plans, and state policymakers to target in efforts to control health care costs for their employees but not at the expense of their access to care.
- A study should be done on how many jobs health reform proposals create or destroy and how it relates to rising or reducing of health care costs.
- Address the magnitude of administrative overhead. We do need to care what health spending buys.
- While not part of testimony, increase awareness, education, and enforcement of the "surprise billing law"
- We need a financially stable safety-net health care system, that includes in a vital way our public hospitals. Support A.6677-A/S.5546 so that we can accomplish some equity in hospital funding for ICP/charity care.

Finally, while I understand some complications and labor union concerns that must be addressed around the New York Health Care Act. We should understand that in fight for Medicare for All, roughly half of all U.S. health spending is currently done

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anthony Feliano

Address: _____

I represent: Commission on the Public Health System

Address: _____

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THE CITY OF NEW YORK

10

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 12/12/2019

(PLEASE PRINT)

Name: Naysha Diaz

Address: 26 Bleecker street

I represent: Planned Parenthood of NYC

Address: 26 Bleeker street

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THE CITY OF NEW YORK

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

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Date: _____

(PLEASE PRINT)

Name: Patrick Kwon

Address: 45 Broadway

I represent: Primary Care Development Corporation

Address: 45 Broadway

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THE CITY OF NEW YORK

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

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(PLEASE PRINT)

Name: LESLIE MORAD

Address: 41 STATE ST STE 900 ALBANY

I represent: NY HEALTH PLAN ASSOC

Address: SAME AS ABOVE

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THE CITY OF NEW YORK

(7)

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☐ in favor ☐ in opposition

Date: 12/12/19

(PLEASE PRINT)

Name: Henry Garrido

Address: 125 Barclay Street NY NY 10007

I represent: Executive Director, DC 37, AFSCME

Address: _____

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

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(PLEASE PRINT)

Name: Andrew Tittle

Address: 555 W 57 St, 15th floor

I represent: Greater NY Hosp. Association

Address: _____

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(PLEASE PRINT)

Name: Larry Engelstein

Address: _____

I represent: 32BJ SEIU

Address: _____

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Sara Rothstein

Address: _____

I represent: 32BJ Health Fund

Address: _____

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Henry Hernandez

Address: _____

I represent: 32BJ SEIU Health Fund

Address: _____

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2

(PLEASE PRINT)

Name: LeChiana Owens

Address: 32BJ SEIU

I represent: 32BJ SEIU

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Elisabeth Benjamin

Address: _____

I represent: CSS

Address: _____

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