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B E F O R E: MARK LEVINE
Chairperson

CARLINA RIVERA
Co-Chair

COUNCIL MEMBERS:
ALICKA AMPRY-SAMUEL
DIANA AYALA
INEZ D. BARRON
MATHIEU EUGENE
ALAN N. MAISEL
FRANCISCO P. MOYA
KEITH POWERS
ANTONIO REYNOSO

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

Kyle Bragg
Secretary Treasury of 32 BJ SEIU

Sara Rothstein
Director of the 32 BJ Health Fund

Edward Kaplan
Vice President of the Segal Company

Miguel Santos
32 BJ Member, Employee at East River Houses

David Rich
Executive Vice President for Government Affairs, Communications and Public Policy at the Greater New York Hospitals Association, GNYHA

Leslie Moran
Vice President of the New York Health Plan Association

Jeanne Pinder
Founder and CEO of Clear Health Cost dot com

Anthony Feliciano
Director of the Commission on the Public Health System, CPHS

[gavel]

CHAIRPERSON LEVINE: Hello everybody, good afternoon. Thank you for joining us. I'm Mark Levine, Chair of the City Council's Health Committee. We're going to be joined in a moment by my Co-Chair for this hearing, which is Carlina Rivera, Chair of the Hospital's Committee and I'm pleased that we are also joined by fellow health committee members Dr. Mathieu Eugene from Brooklyn and Council Member Keith Powers from Manhattan and it looks like we are about to be joined by Council Member Antonio Reynoso from Brooklyn, welcome all. The alarmingly fast rate of increase in health care costs has been a source of enormous concern in New York and nationally for many years. The US spends more per capita on health care than any other developed nation and will soon be spending close to 20 percent of GDP on health. It's not that Americans are buying more health care overall than other countries, it's that what we are buying is increasingly expensive. Today in this hearing we want to focus on a subset of this vexing problem, the fact that some health care providers in this city stand out with costs that exceed even the… even the already high rates of their peers. Recent

news coverage and several studies have shown that costs for similar procedures can vary widely between different hospitals in New York City. In this hearing we'll explore the extent to which rapid consolidation to the hospital sector of New York has accelerated the trend towards price increases with the largest systems now acquiring such strong negotiating power that they can block insurance contracts that steer patients to lower cost providers. We will also examine the extent to which costs are being inflated by the opaque way that hospitals and insurance companies price their services, a problem exacerbated by the hidden details of the grievance between insurers and providers. The wealthiest New Yorkers can indeed afford the most expensive care but for working people runaway costs are inflicting a heavier and heavier burden. This is particularly true for workers and their families who receive their health coverage from a labor unit health fund where high health costs inevitably lead to lower salaries. To that… to that end, we are watching with great concern the ongoing negotiations between New York Presbyterian and empire blue cross blue shield, a despite that could impact the health care of no fewer

than 300,000 New Yorkers. So, we have some high stakes questions to explore in this hearing and I very much look forward to our discussion and thank you all for being here today. I think that Council Member Rivera is coming in, in a second but I, I, I will ask our first panel to, to make their way to the table which will be Miguel Santos… okay, yep… Sara Rothstein, Kyle Bragg, Edward Kaplan and I'm sorry if I'm mispronouncing this, Richard Lorio…

RICH IORIO: Iorio…

CHAIRPERSON LEVINE: Iorio, okay. Okay, welcome Chair Rivera.

COUNCIL MEMBER RIVERA: Thank you.

CHAIRPERSON LEVINE: Pleasure to be co-chairing this hearing with you and I'm going to turn it over to you for your opening statement.

COUNCIL MEMBER RIVERA: Great, thank you… [cross-talk]

CHAIRPERSON LEVINE: Thank you… [cross-talk]

COUNCIL MEMBER RIVERA: …so much everyone. Good afternoon, I'm Council Member Carlina Rivera, I'm Chair of the Hospital's Committee and I want to thank my colleagues of course, Council Member

Mark Levine, Chair of the Health Committee for jointly trying this hearing with me this afternoon. As Chair Levine mentioned, data shows that the United States spends more on health care than any other country in the world with costs that vary widely between institutions and can often be convoluted and complex to understand. There are multiple studies that speak to the enormity of these issues including a study based in California that focused on the varying costs epididymectomies throughout the state. The study found that the cost of this particular procedure ranged from as little as 1,529 dollars to as much as 182,955 dollars within the state. Notably prices varied more by individual institution than their geographic region. Today we'd like to discuss why the cost of a service in one hospital in the city can vary so widely from another. This is a notable problem in our city. In fact, a study by the New York State Health Foundation found that in the down state region of the state the highest priced hospitals are 2.2 to 2.7 times more expensive than the lowest priced hospitals. This discrepancy was higher than hospital cost discrepancies in western and central New York. cost discrepancies among hospitals are

problematic because it leaves ordinary New Yorkers unable to fully compare products like they would in any other business transaction. Every day New Yorkers are left with the sole recommendations of a doctor that while they may be trusted does not often have any information about potential costs to the consumer. This can easily put any one of our neighbors or friends in financial peril. For decades though hospitals and insurance companies have gone back and forth blaming the other for this crisis but in reality both sides owe some responsibility for the differences in cost and the only way they're going to change things is if they own up to that reality and work together to solve these challenges but we can't wait around forever and the disparities in our system are an urgent topic. Today our hearing aims to highlight a critical issue and to also underline why Albany must finally pass the New York Health Act, which would provide comprehensive, universal health coverage for every New Yorker and allow the state to negotiate fair deals with hospitals for procedure costs. We in the council are prepared to do our part whether it is lobbying in Albany or holding a hearing and subsequently passing a resolution in support of

the New York Health Act, which we will be doing next month. In the meantime, I look forward to hearing more about the process hospitals go through to decide their prices and I hope we can get some clarity. This is an issue that effects New Yorker… every New Yorker especially those who cannot afford to pay a single dollar more for health care costs such as older adults, those living with disabilities and those with limited incomes. As we approach a legislative session in Albany with the largest democratic majority in a generation, I look forward to how our discussions here and at future hearings can inform our state colleagues in the pursuit of progressive legislation to address our health and hospital systems. Thank you all. Thank you, Mr. Chair.

CHAIRPERSON LEVINE: Thank you Chair Rivera and we've been joined by fellow committee members Alan Maisel, Francisco Moya. Then we're going to kick it off to our first panel; Vice President Bragg would that be you leading us off?

KYLE BRAGG: Thank you.

CHAIRPERSON LEVINE: Okay, thank you.

KYLE BRAGG: So, good morning Chairs Levine and Rivera and our esteemed committee members.

My name is Kyle Bragg, I'm Secretary Treasurer of SEIU 32 BJ. As you know 32 BJ SEIU represents over 90,000 hard working New Yorkers. We take real pride in the quality of health care benefits we have won for our members. These benefits include premium free family coverage, low co-pays, and a network of thousands of doctors that have real life changing impact in the quality of life of our members. Unfortunately, these benefits are jeopardized by the skyrocketing New York hospital costs. Our health fund has analyzed this data and found real differences in what they pay for the same care at different hospitals. The significant disparity in prices for the same care different hospitals lacks rational justification. I can't understand why health fund has to pay an average of 83,000 for a hip replacement at New York Presbyterian but an average of 58,000 at other hospitals. Millions of dollars are being lost when hospitals are over… can overcharge us for care. We need to find a solution. These higher prices are hurting our members. Every dollar that goes to benefits is a dollar that doesn't go into our member's wage increases. But this problem also has a implications for hundreds of thousands of New Yorkers

who participate in self insured plans. It comes in the context of Presbyterian threatening to leave a network that insures nearly three million New Yorkers. Planned care for 32 BJ members and others at Presbyterian could… would become prohibitively expensive because of high charges. Until we start talking to our members… until we started talking to our members and the public about this issue, no one knew that there was such a variation and what we have to pay to hospitals. Hospitals demand that their contracts and rates be kept secret. This is crazy. What kind of market-based healthcare systems do we have when you can't compare what you are buying before making such an important decision? We know there is a problem and we are calling on elected officials in New York to find solutions to this problem. I want to thank the Council for holding this important hearing and helping to bring transparency to the health care market. Thank you very much.

CHAIRPERSON LEVINE: Thank you. I'll, I'll let you all determine your speaking order unless Sara you want to go next.

SARA ROTHSTEIN: Thank you. Good afternoon Chair People Rivera and Levine and Council

Members. I'm Sara Rothstein, I'm the Director of the 32 BJ Health Fund, a multiemployer plan that provides benefits to union members of SEIU 32 BJ and their eligible dependents. Our plan participants have health insurance premiums that are fully funded by employers that negotiate with the union. 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 and most are here in the New York City Metro area. Our fund is self-insured, this means that the fund, not an insurer pays all the bills for medical claims incurred by our members. We design the benefits in terms of what's covered. We use a third-party administrator and in our case that's Empire BlueCross BlueShield to provide a network and to process claims but we pay them a flat administrative fee. They aren't paid more if our members use more or less services or if we pay higher dollar amounts for care. Empire negotiates rates with providers such as hospitals, doctors, labs but we pay all the bills for the services and we aren't privy to how those contracts are negotiated. Contracts are confidential, and we don't know what the terms are. We get claims data and we're fortunate

to have a team of analysts who analyze the data, so we know where people go for care and what we pay each time they use benefits. After an analysis of our claims data in which we looked at several common inpatient and outpatient services we determined that for several types of care, on average, we pay more at New York Presbyterian and its affiliated hospitals than for the same care at other hospitals. The hospitals in the New York Presbyterian health system include; Columbia University Medical Center, Weill Cornell, New York Presbyterian Queens, Brooklyn Methodist, Lower Manhattan Hospital, and several others in the region. Examples of care in which we, on average, pay more at New York Presbyterian than the average for comparable care at other New York City hospitals include the following: on average we paid New York Presbyterian 82,843 dollars for hip replacements, that's 25,000 dollars more than we paid on average for the same procedure at other New York City hospitals; for bariatric surgery we paid on average 56,858 dollars at New York Presbyterian, that's 11,000 dollars more than we paid on average for the same procedure at other hospitals; for child birth, for vaginal deliveries we paid an average of

23,636 dollars at New York Presbyterian, nearly 7,000 dollars more than we paid on average for the same procedure at other hospitals; for a cataract surgery we paid on average 10,929 dollars at New York Presbyterian, that's more than 6,000 more than we paid on average for the same procedure at other hospitals; and for colonoscopies, on average, we paid New York Presbyterian 8,151 dollars, that's 5,000 dollars more than we paid on average for the same procedure at other New York City hospitals. In our analysis, we selected procedures where there is minimal clinical variation in how the care is performed. This minimized the need to risk adjust, meaning to adjust the numbers if one population is sicker or healthier than the others but we nevertheless took several steps to risk… several steps to risk adjust our findings. The price discrepancies remained even after that risk adjustment. These significant cost differences are important because every time the fund or any other health plan pays more for care than it has to, it undermines the long-term stability of our health plans and ability to provide meaningful health coverage to our members. Thank you.

EDWARD KAPLAN: Okay. Okay, my name is Edward Kaplan, I represent the Segal Company. Thank you, Council Members, for… Committee Members for the opportunity to speak to you. The Segal Company has been around for the 75 years in New York. We provide benefits, consulting and actuarial consulting services to employers, to funds around New York and around the country. I've been with the company 25 years, over 30 years in, in employed benefits consulting. As Sara said most of the large plan sponsors and even mid-sized employers are self-funded, self-insured, over 92 percent of our clients are self-insured meaning they bear the risk of the cost of claims whether it's the hospital, prescription drugs, physician services so whatever they can do we can do the save, save them money goes right to their bottom line in terms of their self-insured benefits which frees up money for wages, pensions and so forth. Our primary goals are to provide strategy, auditing, design, procurement assistant to large clients and mid-sized clients like 32 BJ although they are one of the larger ones. Inpatient and outpatient claims is the number one expense that plan sponsors pay, it's about 35 to 40

percent of all benefits dollars go to hospital inpatient and outpatient services so it's the biggest item, slice of the pizza pie if you will that is… in… most typical employers. Segal has the health data analytics department, actuaries and data scientists look at data and we sign non-disclosure agreements to get individual hospital data from the big carriers and we could only disclose information, we do get price information on individual hospitals but we can only use that data for that particular client, we can't even talk about it publicly which we'd like to do. And when we look at that data, we find great variations in, in hospital pricing in the New York Metro area, down state area. The top hospitals charge a little bit more than two times the average of all the other hospitals for the same procedures when we look at common procedures without any statistical difference in quality that we can determine. So, there is that huge variation, if our clients knew that that would help them make informed decisions on how to negotiate, how to select net, network hospitals, how to exclude network hospitals so it's a very important element to, to be able to get individual hospital pricing. It's a very complex

process to look at DRGs and mischarge… risk, risk scores to kind of adjust to give hospitals their fair analysis to make sure we're accounting for sicker patients by hospital things of that nature to normalize the cost so we are making a fair assessment but that's, that cost are getting… those, those, those adjustment factors are very complex and harder and more costly to… for us to do… to do those analysis for our clients. And last couple of points here is we are aware of the… of the… of the anti-competitive contract agreements between the hospitals and the… and the health insurers, we are a proponent to get rid of those anti-competitive, anti-steering contracts, most favorite nation clauses. Many of our clients want to customize and go directly to hospital X or hospital Y and many of those contracts prohibit my clients from going and negotiating directly or else they're going to jeopardize the rest of their network contracts. So, there's a lot of anti-competitive barriers that we have get over to help our clients save money for their membership. So, basically, I just want to conclude that we do agree and support anything you can do in your efforts to, to remove and prohibit anti-competitive contracts and

to improve the transparency of hospital pricing just like we are pushing for drug pricing as well. Thank you.

MIGUEL SANTOS: Good afternoon. My name is Miguel Santos, I'm a 32 BJ member, I work at the Commercial Office Cleaner in Midtown. I work closely with the union to make sure that our victories lead to fair wages and benefits. Health, health care is… health care insurance is so important to our members and that is why we keep fighting to, to keep costs down, while keeping the quality and care high. I'm here today because I am really worried about our health care. Our benefits are at risk because of care at New York Presbyterian is way too high. We all work together to keep costs down and that is why I think New York Presbyterian should have fair prices for care. I learned from the health fund that an outpatient procedure like an MRI's cost on average is 997 dollars at other New York hospitals, at Presbyterian it costs 2,419 dollars for a procedure that is exactly the same way. If health care… if health care gets too expensive then winning strong contracts with wage increase will be an arduous task. I would like to thank New York City Council for its

leadership, we need transparency, fairness in health care costs. I ask that the hospital like New York Presbyterian treat union members and NYC residents fairly. We need fairness and honesty from our health care providers. Thank you.

RICH IORIO: Hi, my name is Rich Iorio, I'm a member of 32 BJ, I work on East River Houses on 530 Grand Street. My union 32 BJ works hard for all of its members so that we can win strong contracts with real benefits. Our families rely on the health care coverage and good union job. Our benefits are at risk because of the increased cost of hospital care. The staff at 32 BJ health fund work hard to keep our care affordable. That is why I don't understand why care at New York Presbyterian is so expensive. I heard that one year our fund paid 10,929 dollars to Presbyterian for a cataract surgery while at other providers the cost of the same surgery is 4,252 dollars. As a union member I want to know why it's so expensive, since those costs effect thousands of our members. The more we have to pay for benefits, the less there is for our wages. Working families in this city need every dollar, we can't have health care institutions overcharging us while trying to make our

ends meet. I want to thank the Council for holding this hearing… this hearing. You are helping the union households. I call on New York Presbyterian to do the right thing for millions of New Yorkers and work to get the costs under control immediately. Thank you.

CHAIRPERSON LEVINE: Thank you, thanks to all of you. I just want to understand you don't have access to pricing at the hospitals where your patients… where your members are receiving care in any kind of direct way, you've been able to essentially reverse engineer by looking at billing records and therefore compare amongst health care providers, is that right and, and that's how you've discovered discrepancies amongst a wide away of providers, is that accurate?

SARA ROTHSTEIN: That's correct, so when hospitals and insurance companies negotiate rates and negotiate those contracts those contracts and rates are confidential, we don't have the ability to know ahead of time how much care will cost at different facilities. A member of ours will go get care, a few months later we'll get a claim, we take the claims for 200,000 people over years of time and then we analyze that data to figure out what we had to pay

for care at different hospitals and then we look at the differences in what we had to pay at each hospital… [cross-talk]

CHAIRPERSON LEVINE: And so you, you contract with an insurance company, in your case it was Empire and if, if… when you contracted them if you were to say, well we'd, we'd love to hire you but only if you give us transparency on pricing, what would they say to you?

SARA ROTHSTEIN: They would tell us they aren't permitted that the hospitals don't permit them to share the negotiated rates.

CHAIRPERSON LEVINE: Understood. You talked about this anti-competitive clause, that, that means that the hospitals are prohibiting you who are paying the bills from essentially shopping around for the best rates, is, is that accurate, how does that clause work?

SARA ROTHSTEIN: We think there's a few things happening, one is that there's no public disclosure of the rates that hospitals have demanded from the insurance companies so we as a client of third administrators would appreciate having the opportunity to look at all the rates negotiated in

the market and find the best package of rates from third party administrator that we could get, we don't have the ability to do that, the only way we could do that is have one year with one third party administrator, switch to a different one another year, a different another year in order to collect the claims data to do the analysis that is not inefficient or transparent market. The other thing that may be happening is… was reported in the Wall Street Journal about a month ago is that some hospitals and it named New York Presbyterian, have language in their contracts that prohibit third party administrators and insurers from offering flexible or narrow or other types of innovative networks to clients such as ours.

CHAIRPERSON LEVINE: I would imagine that, that the more expensive hospitals would say well we're, we're spending more to provide a better patient experience and that's why patients want to come to us. Do, do you think that's accurate and, and if so, do you… do you charge higher deductibles for the more expensive providers or is that even… that may be not even allowed, I think hospitals probably

don't like that but is that not allowed under your contract?

SARA ROTHSTEIN: I'll answer that first part first and then the second part. In terms of quality we've looked at our claims data and we don't see the quality of care being… at New York Presbyterian being any different than the quality of care at other hospitals in the kinds of care we've looked at. The quality is neither better nor worse. We have asked our third-party administrator as well as other third-party administrators in the markets if we can have flexible networks or if we could have other kinds of network structure and the answer has been no.

CHAIRPERSON LEVINE: Got it. So, the… there are… this, this, this tier and steer model can you explain what, what does that mean and how would that work potentially?

SARA ROTHSTEIN: So, our under… [cross-talk]

CHAIRPERSON LEVINE: Do I have the term correct?

SARA ROTHSTEIN: Sure, so our understanding from the Wall Street Journal and from

other sources is that some hospitals such as New York Presbyterian prohibit third party administrators from offering tiered networks or narrow networks to their clients either could be used to provide more cost effective benefits to members and a narrow network, some hospitals such as the highest cost hospitals could be excluded. In a tiered network, members may have access to all hospitals but might have to pay more to access some of the most expensive hospitals.

CHAIRPERSON LEVINE: You, you… as we mentioned you have pieced this together on your own with no help from either the insurer or the hospital, have any of the parties disputed your numbers either… any of the hospitals or the insurance provider?

SARA ROTHSTEIN: No, New York Presbyterian has neither asked about or data nor disputed it.

CHAIRPERSON LEVINE: Alright, that's important to hear. I want to acknowledge we've been joined by fellow committee member Council Member Alicka Ampry-Samuel, welcome and I'm going to pass it off to Co-Chair Carlina Rivera.

COUNCIL MEMBER RIVERA: Thank you so much. So, you… Chair Levine just mentioned a little

bit about the reverse engineering but typically how are patients or some of your members I guess since that's who you have the experience with, how are they informed about hospital costs?

SARA ROTHSTEIN: So, for the time being they haven't been. We started doing research on our data analysis and our data and we've started sharing the data with our members because we were surprised at how big the price differences are for care at different hospitals and as we've been sharing the data with them, they've been surprised as well. We think it's been valuable to share this information with them and with the public.

COUNCIL MEMBER RIVERA: So, what happens if, if someone with private insurance they receive a bill for a service that was covered by their health plan, but they can't pay?

SARA ROTHSTEIN: So, in our plan one of the things we work really hard to do is to ensure that co-pays are low for covered services and we have used plan design to incentivize our members to use lower cost sites of care. So, for example, our members pay nothing for an x-ray in a freestanding radiology site, they'll pay nothing for outpatient

surgery if they have it in an independent non-hospital owned facility, our members do have to pay co-pays if they get hospital-based care, but the co-pays are low. I couldn't speak to what people would do in other plans where they have higher deductibles or higher co-pays, but I could imagine that some people who are in high deductible plans might have a hard time paying bills.

COUNCIL MEMBER RIVERA: So, what do you think some of the reasons different hospitals would have different costs, I know you mentioned a little bit in your testimony but…

SARA ROTHSTEIN: So, rather than speculate I would just like to share some information that was in the report from the New York State Health Foundation that you cited. So, they said that higher priced hospitals may be higher priced as a result of various forms of market leverage which gives them more bargaining power to command higher prices with negotiating with insurers. Hospitals that have a greater market share are generally higher priced, hospitals that are part of a hospital system with a large regional market share are generally higher

priced regardless of their own size or individual market share.

COUNCIL MEMBER RIVERA: So, why do you believe that discrepancies exist?

SARA ROTHSTEIN: So, I have information that's in the New York State Health Foundation Report, there are a number of health economists who have also looked at price discrepancies within markets. Their theory, which they have looked at the data and they think that data supports is that having a significant market share enables hospitals to demand higher prices.

COUNCIL MEMBER RIVERA: So, you mentioned a number of procedures, you mentioned a hip replacement and cataracts and colonoscopies in terms of the disparities, how, how much time have you… I guess how many procedures more or less do you think you have in terms of pricing and how long did it take you to compile all of that data?

SARA ROTHSTEIN: We're fortunate because we have… a, a fund of our size we're able to have a team of data analysts, it was small it's now bigger, I would say it takes some time for people to get trained up on how to look at this kind of data but

once you start doing it its actually not that complicated and fairly, fairly straightforward and we're certainly happy to share the details of our analysis if anyone wants, we documented our methods very carefully but we have data in additional episodes. We selected the episodes we did because they're amongst the most common so maternity care for example is a third of planned hospital admissions for our members, joint replacement, bariatric surgery also common procedures for our members. Colonoscopy is, we pay for over 5,000 of them a year so we selected amongst the procedures that represent a large share of our clients.

COUNCIL MEMBER RIVERA: I mean the reason why I say that is because… I mean we would and I know that Levine and I we have the same beliefs about transparency and, and that goes with voluntary and public hospitals in terms of the data that's provided, I mean I would love and, and again this is something that we're going to hope to lobby Albany over is some sort of annual report that lists hospital charges for items and services. I think that would be the most transparent way for our systems to operate but in the meantime, you've done your own due

diligence in taking care of your members and, and I'd be really interested in, in maybe sitting down in the future and going over what you've compiled and what you've seen specifically at this institution.

SARA ROTHSTEIN: I appreciate that opportunity.

COUNCIL MEMBER RIVERA: Okay, thank you.

CHAIRPERSON LEVINE: Thank you Chair, and I believe Council Member Powers has a question.

COUNCIL MEMBER POWERS: Yep, thank you, thank you for doing this hearing and thank you for all the testimony. Can you just define the group of people that are affected by this, is it… is it… is it your labor union specifically, is this all New Yorkers that are under different plans, is it those… is it Empire, who is the effected group of people that we're discussing?

SARA ROTHSTEIN: So, the data points that I referenced are for medical services used by our members so union members of SEIU 32 BJ and their eligible dependents but with that said while contracts between insurers and hospitals are confidential, I would imagine that other self-insured

health plans including New York City would face some… same… some of the same pressures.

COUNCIL MEMBER POWERS: Got it and is… and is your… is your price discrepancy in relation to your agreement with Empire then because Empire is your administrator and then they have an agreement with New York Presbyterian, is that how this works so… and if so is that… does that mean others who have arrangements who are or are covered by Empire also experience the same… the same price discrepancies?

SARA ROTHSTEIN: My best guess is that other people who self-insure through Empire would face the same price discrepancies, I can also say that a few years ago we briefly used Cigna as our third party administrator, we took a look to see if the data held during that… if the same patterns held during that period of time as well and they did.

EDWARD KAPLAN: And I can just build on that, you know Segal has done analysis for a lot of building trade unions and employers and it's the same pattern that we see in, in all of those plan sponsors.

COUNCIL MEMBER POWERS: Got it and now have you guys sought any sort of like… I mean you're

doing your own data collection here to help make the case, have you don't any… sought any sort of third party validation to make sure, I mean I, I'm not sure if we're going to hear… you know you, you, you said that you have not yet heard a dispute I guess from Presbyterian meaning that potentially it, it's a valid claim and they're not disputing it but I'm just wondering if there's been an attempt to collect information in another formal way as well to look at how others are affected, the public is affected, you know but also to validate the claims that you guys are… not the claims but the validity of the, the, the price discrepancies?

SARA ROTHSTEIN: Sure, and we're more than happy to share our methodology and discuss it. We feel confident that we've taken all the steps necessary to produce a valid methodology.

COUNCIL MEMBER POWERS: Got that and then I was… I was… has the Office of Labor Relations or any other city agency been involved in this conversation as they… not only your members are, are… you know here are, are public employees but I'm just wondering if as the city agency that oversees

contracts and health care negotiations if they've been brought into this conversation at all?

SARA ROTHSTEIN: So, my understanding is that the Municipal Labor Committee and their health experts and the Municipal Labor Community have been looking at what their costs are with different health systems. The MLC in a letter jointly signed by Bob Lamb and I believe Harry Nespoli sent a letter to New York Presbyterian saying it was the most expensive hospital according to their claims.

COUNCIL MEMBER POWERS: Got you, thank you. And, and about the market share, it… is, is… there was discussion about the higher market share resulting in higher prices and the… is, is the price at… is Presbyterian the highest… do they have the, the largest market share?

SARA ROTHSTEIN: In New York City they're one of the largest… [cross-talk]

COUNCIL MEMBER POWERS: One of the largest, okay, great. Okay, thank you, thanks for answering my questions.

CHAIRPERSON LEVINE: Thank you very much Council Member Powers then I believe Council Member Reynoso has a question.

COUNCIL MEMBER REYNOSO: Yes. Thank you for this information, I know it takes a lot of time and effort to compile this considering the lack of transparency that exists both from the insurance side through obligation and through the hospital side. I do want to say since you have the information have you been able to use it to negotiate with Empire for example and maybe say we don't want to have or encouraging your union members to not go to Presbyterian and in doing so saving them money and then figuring out a way to give that back to the workers if, if there's a… or letting Empire know that you don't want Presbyterian to be one of the hospitals that are under your plan and that… maybe that boosts some leverage and allows you to have more conversations at least, more transparency?

SARA ROTHSTEIN: Yeah, all good ideas and the best of all possible scenarios New York Presbyterian would cut its prices by 30 percent that's what we think it would take to be competitive or on par with the rest of the market. Empire is certainly… understands our position, they and New York Presbyterian have to negotiate a contract and that's really up to them to agree on a contract.

COUNCIL MEMBER REYNOSO: So, you're, you're not allowed to dictate whether or not you even want Presbyterian to be in your coverage?

SARA ROTHSTEIN: So, if we use a third-party administrator, we can only use the networks that they offer to us, right now neither they nor any of the other carriers are able to offer us a network that excludes New York Presbyterian.

COUNCIL MEMBER REYNOSO: I see. So, I'm just thinking here there's a lot of you, a lot of 32 BJ members and if you're talking about Harry, you got some Teamsters that's a lot of folks that are under these, these contracts for health care, maybe there is something that can be done through enough… with enough pressure it's just… you're, you're stuck in a pickle that you can't get out of if there's no one that's willing to be flexible with exactly where you get your coverage because I can imagine if you can dictate that that you would be able to save a lot of money for your members and that would be the ultimate goal, the same coverage less money, I could see that happening. So, this is very eye opening to, to be at this hearing and really hear this and of course anything that I can do or we can do in this council

to be helpful we're going to do but I'm very interested in how you've been… you're stuck between a rock and a hard place but thank you for putting in the effort and getting that information out so that we can start using it and try to build policy that can be helpful. Thank you.

SARA ROTHSTEIN: Thank you.

CHAIRPERSON LEVINE: Thank you Council Member Reynoso. It seems like the insurance companies are so… such a barrier to transparency and in freer negotiations, could you not just cut them out and, and run this yourself and negotiate directly with hospitals, could… maybe… many employers come together to do that citywide and just remove that middle layer that's such a barrier?

SARA ROTHSTEIN: Its certainly something we're exploring.

CHAIRPERSON LEVINE: Okay, is, is… does the data indicate patterns on the types of procedures that, that are, are disproportionately overcharged at some hospitals or is it just haphazard because of the… all, all the, the strange variables that go into the pricing?

SARA ROTHSTEIN: We don't see any clear patters on the types of care.

CHAIRPERSON LEVINE: Council Member Rivera.

COUNCIL MEMBER RIVERA: So, I wanted to follow up on the insurance part because we received some testimony from, from GNYHA and they mentioned that each insurance company has different rules that govern their negotiations with hospitals and so I'm wondering what, what role do health insurance companies play in determining health care costs?

SARA ROTHSTEIN: Given again that that the contracts are confidential and not privy to what rules they're referring to, but I could also imagine that hospitals might have their own set of rules on how they negotiate.

COUNCIL MEMBER RIVERA: And I hope with… as Reynoso mentioned that going forward, we can all work collaboratively to, to, to figure this out so I just want to thank you again for your testimony, for all of you and for taking time off to testify today. Thank you.

CHAIRPERSON LEVINE: Thank you Madame Chair and thank you to this panel, we very much

appreciate you sharing your insight today on this important topic. Thank you.

SARA ROTHSTEIN: Thank you.

CHAIRPERSON LEVINE: Okay, for, for our next testimony we're going to call David Rich from the Greater New York Hospital Association. Welcome Mr. Rich.

DAVID RICH: Thank you.

CHAIRPERSON LEVINE: And please take it away.

DAVID RICH: Great. My name is David Rich with the Greater New York Hospital Association. Our members include all of the hospitals in New York City both public and voluntary as well as hospitals throughout the region. Hospital pricing is an extremely complex topic. Hospitals cover the cost of delivering 24/7 patient care and the other benefits they provide for their communities through a patchwork quilt of set payments from government payers like Medicare and Medicaid and negotiated rates with private insurance companies. Each insurance company has different rules that govern their negotiations with hospitals and some of those rules are set nationally at corporate headquarters in

other states like Indiana, Minnesota or Connecticut. No two negotiations are the same and prices differ from insurer to insurer even for patients utilizing the same hospital. Negotiated rates for one hospital may even differ for enrollees of the same insurance company but who are enrolled in different insurance products offered by the company. For example, a preferred provider organization plan versus an HMO. It is up to the insurance company to make sure that their enrollees and our patients understand what their plan covers, what their out of pocket costs may be based on the rates they have negotiated with hospitals and other providers too; doctors, pharmaceutical companies, etcetera. Only insurance companies know what their enrollees required co-pays and deductibles are that is why Governor Cuomo has directed the state Department of Financial Services to require insurance companies to provide members with information and cost estimator tools. Only the insurers know this information about the many providers a patient may interact with. The New York City hospital market place is highly congested and extremely competitive. In New York City we have six major hospital systems and a number of other

hospitals as well all are competing for patients. This has the benefit of providing many choices for consumers, but it also means that insurers have the luxury of designing narrow networks that may include some hospitals but exclude others. The ability of insurers to play hospitals and systems off each other has an effect on negotiated rates. Its important to note there's a huge mismatch between the size and scope of many of the insurer's hospitals must negotiate with and the hospitals themselves. Our nonprofit hospitals are negotiating with huge national publicly traded insurance companies such as Anthem, which is known here as Empire, United Healthcare and Aetna. These companies have major resources and unlike our hospitals must maximize profits to answer to their shareholders. They are hugely profitable, and their profits have been soaring. United Healthcare reported profits of over three billion in the third quarter of 2018 alone, Anthem, Empire's parent, reported nearly a billion dollars in profits in the third quarter and so did Aetna. These third quarter profits are larger than the entire annual budgets of most of our hospitals. Our hospital's resources are a drop I the bucket

compared to the resources of these for-profit companies. These huge corporations have maximum incentive to pay the lowest possible prices to hospitals, so they can provide a return to their investors. They drive very hard bargains and then engage in practices such as payment denials from medically necessary services to avoid or postpone payments to hospitals as long as possible. These attempts to slash hospital prices only add to these huge profits, is that what we really want? I'm hoping that in the future we'll have a hearing to determine the impact of these company's strong profit motives on the cost of health care premiums and you could throw in the pharmaceutical companies while you're at it. while these bohemus [phonetic] nickel and dime our hospitals to death by contrast hospitals provide care to all New Yorkers of all income groups. They are there for all of us in emergency situations no questions asked. Unlike in other states where most hospitals are not Medicaid providers, all of our hospitals provide high quality medical care for Medicaid patients. The great health care infrastructure our hospitals have created benefits all New Yorkers. Very briefly because this is in my

written testimony, other factors that can cause variability in hospital prices include the relative need to make up for Medicare and Medicaid underpayments, whether or not a hospital is an academic medical center, a teaching hospital or a non-teaching hospital, a hospital's reputation for quality care and qualitative differences which may influence whether an insurer feels the need to have a hospital in its network. So, in closing there are many reasons that rates hospitals have negotiated with insurers can differ from hospital to hospital and from insurer to insurer. What is clear is the old adage, you get what you pay for. If hospitals cannot cover their costs and the losses, they incur from caring for Medicare and Medicaid patients they not only cannot provide community benefits, invest in technologies, expert professional staff and provide good wages and benefits for their unionized workforces but they cannot survive at all. Therefore, we call upon the City Council to support their local hospitals as we know you do and I'm more than happy to answer any questions that you have.

CHAIRPERSON LEVINE: Thank you Mr. Rich. You talk about a competitive landscape for hospitals

today but there's certainly less competition today than there was 20 years ago or even five years ago, the pace of consolidation has been dramatic and its continuing. It seems like basic economics is when a smaller number of players in a market place take on a bigger and bigger market share, they start to gain the ability to push prices up, is that not what's happening?

DAVID RICH: You know I think anyone looking at the different market places in the country and looks at the relative competitiveness of them ours is one of the most competitive, you know as I mentioned if you don't want to go to Mount Sinai you can go to NYU, if you don't want to go to NYU you can go to New York Presbyterian, if you don't want to go there you can go to H and H or one of the other hospitals. We also have some major specialty hospitals like Hospital for Special Surgery, Memorial Sloan Kettering so there's a lot of competition there. It is true obviously that a lot of the hospitals have taken on smaller hospitals, some of that has been at the request of the state because a lot of the other smaller hospitals were in financial difficulty, I think we discussed this a lot at the

last hearing that I testified at but I really don't think… there was an article the other day in the New York Times about competitive market places for hospitals and there weren't any New York examples, they mentioned a note… a variety of other states but they didn't mention New York partly also because we don't have huge for profit hospital chains, we're not allowed to have for profit hospitals in the state of New York, we're the only state where that's true. I'll swear on the country most states have hospitals that are part of multi state chains which we do not have here in New York.

CHAIRPERSON LEVINE: Right, I'll just point out that comparisons to other cities are… they're often smaller markets where you may just have one major player or… [cross-talk]

DAVID RICH: Correct… [cross-talk]

CHAIRPERSON LEVINE: …two and so… [cross-talk]

DAVID RICH: Correct, right.

CHAIRPERSON LEVINE: You, you don't have to have that near monopoly status to begin to exert influence on, on pricing. The other component of, of, of competitive market place is transparency so that

whoever is paying for your services can compare… can comparison shop essentially, it doesn't seem like we have any transparency at all. It seems like its very hard for the people who are determining where to shop if that's the right term, they can't tell where they're getting charged for any given procedure how can you have competition in pricing without any sort of transparency?

DAVID RICH: So, two points to make on that. Starting on January 1st the federal government is requiring all hospitals to have on their internet their charges which is basically like their list price if you will. They for years have been required to provide it upon request now it will have to actually be on the internet. The issue with that though is that that's kind of like the list price, its kind of like when you go to a hotel and you see on the back of the door, you know oh, it's 1,000 dollars for this room but you're paying like 250, that's not the price that most people pay and its not the price that insurers pay because they've negotiated down from there on behalf of their enrollees so that's why Governor Cuomo and others and others at the federal level have said it really needs

to be… and, and hospitals absolutely need to let people know what their prices are but it's really the insurer who knows what product someone is enrolled in, what services that covers, what prices they've negotiated for each of those different products because sometimes they negotiate different prices for those products. The hospitals don't know a person's co-pay or deductible or what their other out of pocket costs would… should be and that's why Governor Cuomo has said the insurance companies should have cost estimator tools on their websites so that somebody could go to their website, it's something that a 32 BJ member could do if Empire had it, go to their website and say okay, I want to go here versus here what would that mean and, and by the way the hospitals would only know their price, they wouldn't know physician group prices, they wouldn't know if someone needs home health care afterwards what that price is, they really only know their particular price and whatever they've negotiated. I should also say it sounded like everyone thinks hospitals demand all of these contract provisions, from our perspective it's the payers that want the confidentiality, they don't want Mount Sinai to know

the rate they've negotiated with NYU versus New York Presbyterian versus H and H because if they… then if the hospital finds they negotiated a better price for one of these others they'll demand it the next time they have contract negotiations and that's why those confidentiality… [cross-talk]

CHAIRPERSON LEVINE: Well it seems like you have at least one pair who testified who would rather have more transparency. I think most people understand that a university medical center might be more expensive than a community hospital or a public hospital but assuming you don't dispute the data that we've heard already today how do you explain great disparities in pricing between and amongst university hospitals right here in New York City?

DAVID RICH: You know I can't really explain it because I don't know the data myself and I'm not really here to speak to one specific situation because I'm not… that's not my… I don't… that's not my purview but I do think that, and I mentioned in my testimony a variety of reasons that there could be disparities. I should point out that the rates that are being paid are rates Empire agreed to in whatever their last contract was and we've seen

Empire do this in a number of cases around the state where they have a contract negotiation coming up and I'm… and this is not in the case of 32 BJ because they did the… they ran the data themselves but they've also often put out data, they did this with Westchester Medical Center a few years ago, they did it with Manasa Hospital earlier this year, data that nobody can quite replicate and again I'm not saying that's true in this case to try to get people on their side in a contract negotiation. We've seen it not just with Empire and Anthem, but we've seen it with United Healthcare, Aetna, all the different players. So, you know why would… if… should the data be true and I… and again I can't comment on that and I'm not… I'm not disagreeing with it, I think the person to ask would be Empire, those are rates that they negotiated to… they negotiated and signed on the bottom line to, so it seems to me they're the ones to ask why they pay the rates that they do.

CHAIRPERSON LEVINE: Okay, thank you. Chair Rivera.

COUNCIL MEMBER RIVERA: Yes, thank you so much for being here.

DAVID RICH: Uh-huh…

COUNCIL MEMBER RIVERA: So, we're, we're just… we're really just trying to figure out how a lot of these charges are determined and costs and how, you know New Yorkers can just better prepare and know… and know what tools are available because even the calculator that you mentioned you said in, in kind of your remarks said even that would… is flawed because you're not quite sure kind of pre and post whatever it is that you need what you're individual family necessity is. So, charges are, are different from costs but, but they are presumably correlated so why would one hospital have much higher charges than, than others?

DAVID RICH: You know they all set their charges themselves and the federal government then requires that and requires them to have a set number of charges they do that because some, sometimes the federal government through Medicare, the state government through Medicaid has reimbursement rates that are based on cost and so they have these complicated calculations to determine what the difference between… you know what is the markup and I think that's a little bit of what you're asking. I do not know why one hospital would have, you know major

higher charges than another other than the examples I gave in my testimony. So, an academic medical center that is a huge teaching center that gets sicker patients than community hospitals because when you need… you know as you know if you go to a community hospital but you have a very serious condition you might get transferred to an academic medical center so their cohort of patients tend to be sicker at an academic medical center or a major teaching hospital than others so those are some of the reasons and you know just some of the infrastructure that they have to have in order to make sure that, you know their medical students are learning everything they need and seeing everything that they need to see their residents are being trained on the latest technology. They also compete with, you know hospitals across the country outside of New York so there could be a lot of reasons why their charges are higher than others, but I can't give any specific examples of why hospital A might have higher charges than hospital B.

COUNCIL MEMBER RIVERA: You mentioned reputation as one of the reasons, you said that that has an impact on contract negotiations, can you talk a little bit about what you mean by reputation?

DAVID RICH: Sure, I think if you were an employer and you were providing health insurance for your employees you would want to know from them which providers you'd want to make sure were going to be available to them, which hospitals, which doctor groups, etcetera and so you know consumers have strong opinions about where they want to go. They also have strong opinions about their physicians and where their physicians have admitting privileges. So, you were asking about steering and tiering before, you know one of the… and that's basically meaning as you know that you sort of put providers in different tiers based on cost, hopefully based on quality as well but we've seen it more across the country based on cost and then if your enrollee goes to tier one they pay lower premiums and co-pays and deductibles, they go to tier two they pay more, tier three they pay even more. So, one of the issues there I would think consumers would have is if they have let's you've been a long time patient of a doctor that admits to Mount Sinai and suddenly the insurance company puts them in tier two or three, you as a consumer might suddenly have higher costs than you had before because now they're trying to steer you to

a different provider not the one you've been going to for years that your doctor has admitting privileges at and that could be a real issue for consumers I would think.

COUNCIL MEMBER RIVERA: And just something I, I asked the panel before you on how are patients informed about hospital costs, do you feel like the, the members in your association are, are doing their best to be up front about what consumers can expect?

DAVID RICH: I think they are, I think there are improvements that can be made, and I did mention that starting in January there's going to be the requirement that all of their charges be online, I think that some actually have been trying to do patient calculators as well on… of their own. What I mentioned before though that makes that difficult is that they can't always know when a patient calls and says… because so many of us, you know we have Empire, we have United Healthcare, we might have another plan but we're not really that conversant in what that means or what it covers or, you know even how much of your deductible if you have a high deductible you've already spent during the year and so it makes it very

hard for a provider, a hospital or a physician group, another homecare agency or whatever it might be to be able to say this is exactly what you're going to have out of pocket. That's why I said it's really the insurer that has all of that information, they know what's covered. As the… as the person from 32 BJ said they, they decide what's covered in different plans that they offer, and it isn't really the hospital that would know that. So, I think, you know always improvements can be made and I'm not at all saying its only on insurers to help consumers understand, it's certainly an important hospital function as well but they really do hold all the data. When someone is uninsured that's when the hospital really needs to especially work with people to let them know what costs might be and all of the hospitals have on their websites what their financial assistance plans are, they put on there… they're required to put on their bills under state law, you know if you need help with your bill we have a financial assistance policy and here's, here's what it is. The state law on financial assistance policy says that you basically can't charge more for certain income levels than the Medicare rate of the Medicaid rate or, or you know

the most prevalent private insurance rate that you have and then it also needs to be on a sliding scale so when it comes to in… uninsured people that's how hospitals deal with the uninsured. They're pretty much the only providers that take care of uninsured individuals but that's how they deal with that… with those patients who mainly come in, in emergency situations unfortunately.

CHAIRPERSON LEVINE: Thank you Chair Rivera. The transparency for the uninsured is, is welcome, nothing like that on the insurance side at the moment and it… would you commit to work with us to bring more transparency to pricing for insured patients?

DAVID RICH: Absolutely and, and as I said I think and I can provide with you and would be happy to the American Hospital Association working with the Health Finance Management Association came up with a whole price transparency recommendation paper where they talked about how… like I just said when its uninsured patients that's where hospitals really have to sort of do the most work, when it comes to insured patients it's really the insurers that have all of the information including how much

of your deductible you've already spent that year that's not something a provider will know and so that's… you know I'd be happy to share that paper with you, I think it's a really excellent issue brief that can help inform, I think we might have shared it with some of your staff that can help inform your discussions going forward.

CHAIRPERSON LEVINE: You mentioned that there's no for-profit hospitals in New York, but we sure allow for profit insurers… [cross-talk]

DAVID RICH: Yes… [cross-talk]

CHAIRPERSON LEVINE: …and they are dominating more and more of the market but there are still nonprofit insurance providers in the city, are they a more, more benevolent actors and maybe we need to be steering more employers towards those kinds of nonprofits.

DAVID RICH: They are, a lot of them though… because you know Empire used to be our big not for profit blue cross blue shield plan and then it converted and got taken over by Anthem. Most of the non for profit insurers in the city at least tend to be Medicaid managed care plans who may also provide Medicare advantage products, a lot of them

are provider based so for instance health first is one that we actually started for the Medicaid population and is, is owned by a number of our hospital members and Metropolis, which you're very familiar with as well is H and H's version of that and so that's what they tend to be, they tend to focus on low income populations and government populations and they're a little bit less in the commercial space if you will. The place where that varies some is a lot of them participate in the ACA New York State of health type plans which are characterized as commercial plans but again those tend to be people up to a certain income level.

CHAIRPERSON LEVINE: Thank you very much Mr. Rich…

DAVID RICH: Thank you very much.

CHAIRPERSON LEVINE: And we're going to go to our next panel which is Leslie Moran from the New York Health Plan Association; Jeanne Pinder from Clear Health Costs and Anthony Feliciano from the Commission on the Public's Health System. Okay, welcome, would you like to kick us off?

LESLIE MORAN: Certainly. My name is Leslie Moran, I'm the Senior Vice President of the

New York Health Plan Association. We represent health plans across the state. Most of the… both the commercial plans as well as the plans that are serving largely government sponsored enrollees. I just wanted to make one comment following up on Mr. Rich's comments that health plans… all of the health plans in New York State are required by law both under the affordable care act and the New York State law, they are required to spend at least 82 cents of every dollar on health care so that's just to his point that its going to profits and not to health care so it is going to health care. We appreciate the opportunity to share our views with you, we are equally concerned about the rising costs of health insurance… or health costs and the affordability of health coverage, it's the number one challenge that faces employers and consumers and this health insurance premiums reflect the cost of care, the high prices that are charged by some providers exacerbates the challenge. Increases in the cost of hospital services both inpatient and outpatient is one of the largest factors that drives up health premium costs. I think you heard earlier that about 35 percent of, of costs… of health care costs is directly

attributable to the inpatient and outpatient services. Hospital costs are increasing even as utilization of services is going down. Data that came from the health care cost institute shows that between 2012 and 2016, the prices for inpatient hospital services increased by 24.3 percent while utilization for services actually decreased by 12.9 percent. New York has some of the highest health care costs as Chairperson Levine noted, we have some of the highest in the country, they're marketable higher than the national average and as noted the hospital costs are a main contributor to that statistic. Although the focus of today's hearing is New York Presbyterian, we would urge… we think it's a mistake for the council just to look at this one facility because there are others as well that have extremely high prices and should be looked at as well. The variation in hospital prices is driven by the market leverage of certain providers. As Chair Rivera noted, the New York State Health Foundation did a study looking at price variation. That study highlighted market… the… highlighted the market disfunction. Among the findings the wide variation in provider prices is not based on quality, equity or complexity.

It also said that higher priced institutions draw greater volume from lower priced institutions and a hospital's market leverage or its bargaining power when negotiating with insurers is a key factor in the prices that a hospital can command. The study found that price variation exists across the… across New York State but as Chair Rivera noted, its greater in the downtown region… or the down state region. It also found that hospitals command a larger… that hospitals that can command a larger market share are generally higher priced and hospital participation in a hospital system with significant regional commercial market share can influence higher hospital prices as well. We believe that addressing price variation should benefit employers and consumers, any effort to address variation in provider prices should align with the following principles; provider prices may vary for justifiable reasons including quality of care, equity, regional differences and patient mix but they should not vary due to size, geographic isolation or market clout. Reducing variation in provider prices should result in a meaningful relief for consumers and employers by lowering health care costs. And reducing provider price variation should

focus on rebalancing the current health care spending and not imposing new fees or assessments that will increase costs on employers and consumers. Approaches to address the price variation should include measures that prohibit anti-competitive provider contracting practices, which you heard about earlier; those serve as a barrier to promoting greater competition in the market place. They should also focus on increased transparency of health care costs and more affordable options for employers and consumers. Again, thank you for the opportunity to offer our comments.

CHAIRPERSON LEVINE: Thank you for speaking.

JEANNE PINDER: Thank, thank you for having us. My name is Jeanne Pinder, I'm the Founder and CEO of Clear Health Costs dot com. We're a journalism start up based here in New York City bringing transparency to health care by telling people what stuff costs. I come here as a journalist, I spent 25 years at the New York Times as a reporter, editor and HR exec, I volunteered for a buy out and a year to the day later won a shark tank type pitch contest to build this company. [clears throat] sorry…

So, how we do it, we use shoe leather journalism, crowd sourcing, data journalism and investigative journalism to tell people what stuff costs in health care. We do this work not only on our home site but also in partnership with other big news organizations. So, how its done, we have interactive software that has data in it we collect data and then we encourage people to share their prices too. So, this interactive software you can think of it as something like a mash up between Kayak and the Waze traffic app telling people what stuff costs in health care. By the way we don't need legislation or regulation we just want out and did it. You might be surprised to know that a simple blood test could cost 19 dollars one place or 522 a few blocks away. The same simple MRI could be 475 dollars or 6,221 dollars about 20 miles away. So, what we do is in displaying these prices we give people a real… oh, thank you… agency and we help them save just by revealing prices as journalists. They… we also make great journalism out of it so we don't just show the data, we make stories about to avoid that facility fee, how to figure out why your colonoscopy doesn't have to be 6,000 dollars, it can actually be 1,200 or how to get

that blood test for 19 dollars rather than 522. In New Orleans we saved one woman 3,786 dollars on a simple MRI. In San Francisco one man saved 2,010… sorry, 1,270 dollars by putting away his insurance card and paying cash. A guy in Mousula used our data to save 2,010 dollars by successfully challenging a bill. I could go on and on. We actually think that journalism is the solution. What if all the time and money is spent on secrecy was erased from the system? What if we all knew prices in advance? What if we could actually call and get a straight answer about how to get that blood test for 19 dollars rather than 522? What would happen if we searched for an MRI on google and we got a bunch of price cards that dropped down the way you get price cards that drop down when you search for an iPad? So, that's what we're doing.

CHAIRPERSON LEVINE: Thank you very much, Anthony.

ANTHONY FELICIANO: Good afternoon, my name is Anthony Feliciano, I'm the Director of the Commission on the Public's Health System. Let me first start by saying that disparities are also in the quality and the care. While some of you already well said others are in desperate need of access and

better care. Even though I would state that yet there's no direct correlation between cost and quality, it makes it even more complicated and the hospitals charge widely different prices for similar care. For example, the state produces reports comparing costs for specific common diagnoses. The median cost of a patient discharge in 2014 after a cesarean delivery with minor severity ranged from eight… a little bit over 18,000 reported by New York Presbyterian downtown to a little over, over 6,000 from Mount Sinai Roosevelt. It is super complicated to explain why care at one hospital appears to be nearly three times the cost of care at another, but we can say that, that it is just only bargaining power we're negotiating with insurers, we think it's also the different ways the two institutions, institutions allocate and report costs. Sometimes interpreting the, the data varies in many ways; it could be attributed to many factors; over, overall value, teaching hospital status, facility specific attributes, geographic region and care of, of quality of care provider. We would add also that it also has to do with the huge socioeconomic issues and problems most commonly framed as Social Determinants of

Health, the way hospitals serve communities. And I would just state that, that there's not transparency and also the uninsured, the way its reported so it's not just that… it's not accurate there how that was being stated earlier. Particularly we know there's not public data for insurers in negotiated contracts however we think that perhaps when you look at a lot of the higher cost hospitals doesn't seem… means that they're giving higher quality care, doesn't also mean that they're giving lower costs, it means that they're giving lower quality care as well. So, we need to differentiate that as well but also some of those hospitals that are higher, higher cost also have… many of them do have bad safety standards as… well safety, safety ratings as well so you have to look at that as, as one area. Some of them have a D or, or worse in terms of safety. You know that one time… I mean inpatient care before the 80's, inpatient discharge, inpatient that was once a standard measure of hospital efficiency and utilization today there's more patients that account for more than half of what the hospital share is but one thing that widely could be used is, is the ratio part and so I want to just skip because I'm jumping

around here. Let me think about the yardstick, the comparing cost that could be very important. I think the most meaningful and accurate method might be comparing the actual cost of care for a… for a similar patient in a different hospital, that's, that's still very complicated, that's one thing. Including… I think we, we should also look at is… and I'm looking over here… the institutions… one of the other yardsticks comparing cost could be also… is payroll cost per adjusted discharge. Payroll expenses per adjusted… could be wages, benefits and training looking at all those categories and most of that is required to institute cost report, but I think that's another way of looking as a yardstick to look at cost because the other variables may be very complicated. Let me just finally state that we really should address the disparity in cost because there's also a disparity of the care. If… there are… you know New York City provided like 669 million in real property tax exemptions to private nonprofit health care providers. Some of those do not provide a public care and have high costs and so I think we need to look at disparities in many ways and, and although its not correlated around quality there is issues there

including the high CO salaries that we have for some of these for profit… for profit, private insurers. And someone mentioned about New York State, you know in terms of only having non-for-profit hospitals which is obviously true but there's also a worry that they… and just thinking of cost that maybe… many times it has been in state legislation to go into for profit hospitals allowing them to come here. I would think you would need to look at that very deeply because sometimes privatization doesn't ensure efficiency or any, any lower costs. These are the key… to me is really about the, the community and about the workers and the fact that we tossed around between the insurance company and the hospitals is unfair and its not just. Thank you.

CHAIRPERSON LEVINE: Alright, thank you for that very important and powerful statement, Miss Moran can you clarify, your members are all the health insurance in New York State, all of the for profits… [cross-talk]

JEANNE PINDER: No. Excuse me, we represent most of the health plans in New York State, there are just a, a couple… one of them upstate, Acellus we don't represent and a couple of the plans

downstate but most of our plans and we come… we have for profit and not for profit and there are actually I would think more non for profit plans in New York State than there are for profit plans.

CHAIRPERSON LEVINE: Okay, so we heard from 32 BJ, from the employer's side who wants more transparency, we heard from the Greater New York Hospital Association, they want more transparency…

LESLIE MORAN: We encourage transparency as well.

CHAIRPERSON LEVINE: So, how is it that if all three parties are calling for more transparency, we have incredibly opaque contracts?

LESLIE MORAN: Well its largely because the, the plans are not able to release their contract terms with the hospitals, I mean the… its… we would like to see more transparency in terms of hospital costs so that we can better understand the, the disparities between different hospitals, why the costs are so much higher at one hospital than another…

CHAIRPERSON LEVINE: Alright but you, you hold the most information, you know how much you're paying everybody for every kind of procedure that…

even a group like 32 BJ which can kind of reverse, reverse engineer it doesn't know as much as you.

LESLIE MORAN: But as Sara pointed out its usually because we are not… the plans are not allowed to release those… that information from the hospitals, don't want us to release the information.

CHAIRPERSON LEVINE: But you're saying you would like to?

LESLIE MORAN: We're saying we, we think we should work collaboratively to increase transparency through… across the system.

CHAIRPERSON LEVINE: Okay.

LESLIE MORAN: And, and one of them is, is through, you know these cost estimators, all plans have cost estimators on their website, they're required to. I think one of the things Mr. Rich pointed out was, you know the, the different types of plans that are people… that, that people are in and he talked whether a person know whether they had a… you know how much of their high deductible plan. He was really referring to when they're going to an out of network facility, I think what we're focused on here is when people are going in network, when they've done everything that they should be doing

anyhow and so they're protected in terms of their cost if they go to an in-network hospital.

CHAIRPERSON LEVINE: Okay, seems like we need to get the hospitals and the insurance companies in a room since everyone separately is claiming they believe in transparency so that no one can pass the buck on that. Miss, Miss Pinder based on your data analysis do you concur with the analysis that 32 BJ did about discrepancies and pricing?

JEANNE PINDER: Yes, we see that kind of discrepancy everywhere. In fact, even bigger ones, we've seen a 20X Delta in some places, its quite startling really and we do believe that the only answer is transparency. We'd be cheerful and happy to be an intermediary to help display that data because if anybody wanted to share data with us be it individuals or institutions, we do have software that actually displays it in that sort of mash up of Kayak and Waze dot com.

COUNCIL MEMBER RIVERA: So, it's interesting that you mentioned kind of how your… the site runs and so I'm curious as to how you receive some of the feedback. For example, you mentioned

something… a, a person in New Orleans, a person in Montana… [cross-talk]

JEANNE PINDER: Yeah… [cross-talk]

COUNCIL MEMBER RIVERA: …how did they reach out to you and let you know that your web site helped them save money?

JEANNE PINDER: Right, so our interactive software lets people contribute their pricing information on our site, so they can put their data in and be instantly represented in our data base. We also get found a lot via search engine optimization SCO, google loves us so when people go and… the guy in Mousula was trying to figure out what his CT scans should cost so he typed into doctor google how much does a CT scan, scan cost, found us and started explaining his sad saga, we helped him argue his bill and saved him 2,010 dollars. Also, some… [cross-talk]

COUNCIL MEMBER RIVERA: You should allow reviews then like Yelp.

JEANNE PINDER: We can't… well we let people chime in and tell us stuff and then when we hear stories like that, we do blog those. So, the woman who saved the 3,786 dollars came up to us, actually she was in a news room and she came up to us

and explained how she saved 3,786 dollars so sometimes it's in person feedback. We have a voicemail line, we let people call in and tell us things.

COUNCIL MEMBER RIVERA: So, in our Committee Report its mentioned that, that larger hospital systems tend to have more bargaining power to reach cost agreements with insurance providers and we heard from Greater New York that again and, and I, I say this in trying to understand and determine why these discrepancies and these disparities exist but, you know from what I heard from Greater New York it really does lie with the insurance company as to how much they're charging and we're not just picking on one hospital we, we agree that across the board these, these disparities exist. So, would you… would you agree that with hospital consolidation that they do have more power to kind of negotiate more people are paying?

LESLIE MORAN: Yes, and it's not just our thought but there's data that shows that, I mean both in the health foundation report. While the New York Times article didn't look at any specific New York State or New York City hospital systems, certainly

that New York Times story did point out that hospital consolidation has led to higher prices, its, it's a national phenomenon and one of the things, you know we hear when we, we've participated in some of the state health department's… it's the Public Health Planning and… the Public Health and Health Planning Council looks at when hospitals have consolidation applications in and we've been going to those to actually testify and as I said there is data across the country that shows that these consolidations have led to higher prices and one of the arguments that is always used when the hospitals come and say we need to consolidate because it will give us greater efficiency and that will in turn give us the ability to lower our costs but there's no kind of back end look at has that actually happened so we have encouraged the State Health Department through the Planning Council to say… to come back and say there needs to be a demonstration that you've actually recognized and realized these efficiencies and that you are lowering costs and passing that lower cost onto consumers. Unfortunately, that hasn't happened yet.

COUNCIL MEMBER RIVERA: And I appreciate what you're saying, I mean I think consolidation claims and being unverified is, is a pretty serious issue and goes kind of to the root of what we're discussing today. So, Mr. Feliciano I had… I have a… I guess a question, you are… you work with a lot of advocates, community members and you work with medical professionals so how… with hospital consolidation and staying on this topic how's… how has your work changed as a result of hospital consolidation and how have changes impacted the communities that you work with and serve?

ANTHONY FELICIANO: I can spend the whole discussion on this part, but it's come down to a lot of the quality and the access to services and programs. Consolidation has been based on the New York State looking at a flawed formula around over bedding is one of them, there's obviously mismanagement but I don't think as prevalent as others may think but I, I do believe that the way reimbursement goes and the state has also impacted that, there's an inequity in almost all, all the formulas in all of the particularly… so access and quality gets impacted greatly. You have communities

that go without care although there hasn't been real studies that show when a hospital closes what was the impact in terms of the access but there's shown that over all of the consolidations that have happened or sell… or mergers or selling of property most of it has not benefited the community at all, there have been real estate deals that have just made luxury housing so it doesn't really… doesn't help at all. I think part of it is also the, the ability for communities to be sitting and, and deciding in resources of how those resources get used in their community and so I think the overall big issue has been the idea of or a lack of community health planning and, and involving community in the design and the decision and that's been the big impact also on consolidations and mergers.

COUNCIL MEMBER RIVERA: Uh-huh, thank you, I want to recognize Council Member Ayala has joined us and I believe Council Member Barron you had a question.

COUNCIL MEMBER BARRON: Thank you and thank you to the panel for coming and sharing your information. So, I had the opportunity to google

Clear Health Cost and the site seems to be very straight forward…

JEANNE PINDER: Thank you…

COUNCIL MEMBER BARRON: Do you only rely on persons who share their data with you, do you have… okay, so can you share with us how you… [cross-talk]

JEANNE PINDER: So, yeah, so we're journalists, we do a pricing survey on common shoppable procedures, it's the core of our data set, 30 to 35 common procedures. We call providers and ask them their cash or self-pay rates, so what would they accept as a cash price for that MRI, that's right without insurance… [cross-talk]

COUNCIL MEMBER BARRON: Okay… [cross-talk]

JEANNE PINDER: …and then we allow in… we encourage people to contribute their data, we also have on this site the Medicare rates for every procedure in everyone… of every zip code based on COUNCIL MEMBERS data. As you probably know the Medicare rate is the closest thing to a fixed or benchmark price in the marketplace. So, if you look at the San Francisco MRI CPT code 72148 you can see

that the prices there range from 475 up to 6,221 dollars where Medicare pays 580. So, you have something to navigate with, we didn't actually tell you how much your insurance company is going, going pay or what your deductible did but we do give you a way of navigating and have agency in the marketplace. So, if somebody offers you a 6,221-dollar MRI you can say no, thank you.

COUNCIL MEMBER BARRON: So, the first panelist Miss Moran, I believe you said that there are cost estimators that insurance companies use or project post… and it talks about the out of network cost?

LESLIE MORAN: It, it… they can use cost estimators in a variety of ways but they… plans are required to have cost estimators on their websites and a lot of plans are actually partnering with Fair Health, which you may be familiar with which enables people to look at what their costs are going to be, what their out of pocket costs might be.

COUNCIL MEMBER BARRON: So, Miss Pinder have you found that the cost estimators that are online or that are posted are accurate or do they… do they match what it is that you have found?

JEANNE PINDER: No, the online cost estimators by insurance companies… [cross-talk]

COUNCIL MEMBER BARRON: Uh-huh… [cross-talk]

JEANNE PINDER: …are uniformly terrible and there's no accountability, sorry.

COUNCIL MEMBER BARRON: Thank you.

LESLIE MORAN: It, it is something that the Governor has talked about, creating kind of a, a universal cost tool… [cross-talk]

COUNCIL MEMBER BARRON: So, why aren't they accurate?

LESLIE MORAN: I really can't speak to that because I'm not intimately familiar with each plan's cost estimator, I mean a lot of them you have to be a member to actually get your cost, but they also have a public facing, you know… [cross-talk]

COUNCIL MEMBER BARRON: So, the cost might be different for different members?

LESLIE MORAN: They could be based on what type of product they're in whether they're in a PPO or an HMO product so there could be different costs… [cross-talk]

COUNCIL MEMBER BARRON: So, the cost estimator wouldn't differentiate that based on… [cross-talk]

LESLIE MORAN: It, it should if you enter in all of the information and again I… without actually looking at one and testing it I can't speak to the complete accuracy of them.

COUNCIL MEMBER BARRON: Okay, thank you.

LESLIE MORAN: Thank you.

COUNCIL MEMBER RIVERA: So, I think Greater New York said it was like a list price and there's all these factors and it's like the back of the hotel door and I'm wondering… I, I guess I want to ask you specifically Miss Moran is what role do insurance companies play in the pricing, why do the prices… why do the prices vary in the same hospital?

LESLIE MORAN: We don't play any role in hospital pricing that is completely dictated by the hospital.

COUNCIL MEMBER RIVERA: Okay, I wanted to just ask Anthony one follow up to, to what you mentioned and… in terms of what kind of additional support would you like to see to help us kind of meet the needs of the community? We mentioned transparency

but… you know I also feel like the conversation has led to whether or not the transparency is actually going to be worth anything, so I wonder what are some of the resources or, or what additional support you would like to see to better meet the needs of your community?

ANTHONY FELICIANO: As an advocate… as an advocate transparency is always important for accountability. Just to mention the charges, list of prices can sometimes underestimate as well so, so that's an issue. I think there really needs… and I'll be very honest, there's a political issue, this is about who lobbies for the money and who lobbies for the resources and where it gets distributed and who makes the policy decisions and so if we're going to have transparency then it just cannot be the insurance plans and the hospital sitting at the table with the Governor and deciding what needs to be happening, it needs to be labor, it needs to be community and thinking about design and the formula, this is the same thing that's happening right now around Charity Care changing the formula, you know to, to be more equitable across the board so there's a transparency issue across everything that… in terms

of the distribution of those dollars when it comes to the state. I think the City Council has the ability to use it ability to push back at some of these things, I think it's also to make sure we protect the protect the public hospital system who are part of that two, two tiered system where you have people who are served and people who are not served within the system and that plays out in costs also and in quality of care. I would think that we will look at some of the real, real property tax exemptions that the city gives to the hospitals, I think we need to look at… like I mentioned before a good yardstick to look at the payroll costs per adjusted discharges to think that through, that is one area. I think every formula has its flaw, you're not going to get a perfect assessment, but you really need communities to be able to understand the cost of their care and then the quality of that care all across the board.

COUNCIL MEMBER RIVERA: Thank you. Are there any more questions from the Committee? Thank… yeah. Okay, well I just want to thank you, thank you so much for your testimony and for all of the work that you do and to everyone here, I don't there are any more members of the public who wish to testify

today. Okay and with that this Committee meeting is adjourned, thank you.

[gavel]

C E R T I F I C A T E

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

Date December 12, 2018