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# COMMITTEE REPORT OF THE LegisLative Division

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**COMMITTEE ON HEALTH**

*Hon. Lynn Schulman, Chair*

**COMMITTEE ON HOSPITALS**

*Hon. Mercedes Narcisse, Chair*

**Int. No. 0844-2022:** Council Members Menin, Schulman, Narcisse, Abreu, Brannan, De La Rosa, Stevens, Bottcher, Feliz, Ung, Williams, Sanchez, Krishnan, Dinowitz, Hanks, Ariola, Velázquez, Louis, Hanif, Marte, Lee, Avilés, Ossé, Salamanca Jr., Riley, Cabán, Joseph, Brewer, Gutiérrez, Brooks-Powers, Restler, Moya, Richardson Jordan, Hudson, Ayala, Nurse, Gennaro, Won, Farías, Powers, Paladino, Vernikov, Kagan and Public Advocate Williams (by request of the Manhattan Borough President) (by request of the Queens Borough President) (by request of the Brooklyn Borough President) (by request of the Bronx Borough President)

**Title**: A Local Law to amend the New York city charter, in relation to establishing an office of healthcare accountability

**Preconsidered Res. No.** Council Member Menin

**Title:** Resolution calling on the New York State legislature to pass, and the Governor to sign, legislation to create an independent Commission to oversee hospital services pricing for the purpose of increasing access to hospital services, promoting financial stability for hospitals, and lowering healthcare costs for New Yorkers.

1. **INTRODUCTION**

On February 23, 2023, the Committee on Health, chaired by Council Member Lynn Schulman, and the Committee on Hospitals, chaired by Council Member Mercedes Narcisse, will hear Introduction Number 0844-2022 (Int. 844), sponsored by Council Member Menin, a local law to amend the New York city charter, in relation to establishing an office of healthcare accountability. The Committees will also hear Preconsidered Resolution Number (Preconsidered Res. No.), sponsored by Council Member Menin, calling on the New York State legislature to pass, and the Governor to sign, legislation to create an independent Commission to oversee hospital services pricing for the purpose of increasing access to hospital services, promoting financial stability for hospitals, and lowering healthcare costs for New Yorkers. Those invited to testify include representatives from the Department of Health and Mental Hygiene (DOHMH), the Health and Hospitals Corporation (H+H), interested stakeholders, and other members of the public.

1. **BACKGROUND**
	1. **Federal Hospital Price and Health Plan Price Transparency Rules**
		1. ***Hospital Price Transparency***

The Centers for Medicare and Medicaid Services (CMS) is part of the United States (U.S.) Department of Health and Human Services (HHS). CMS aids the public “as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.”[[1]](#footnote-2) CMS issued a rule that went into effect on January 1, 2021, which requires both hospitals and insurers to make their negotiated prices public.[[2]](#footnote-3) According to CMS, the Hospital Price Transparency Final Rule sets forth requirements for complying with § 2718(e) of the federal Public Health Service Act,[[3]](#footnote-4) which requires hospitals to make public their standard charges.[[4]](#footnote-5) CMS states that the public release of hospital standard charge information is “important to ensuring transparency in health care prices for consumers” while also helping to address some of the barriers that limit price transparency.[[5]](#footnote-6) CMS also notes that while the “rules we finalized are a required floor, they do not preclude hospitals from undertaking additional transparency efforts beyond making public their standard charges.”[[6]](#footnote-7)

Under the final rule, hospitals must provide clear, accessible pricing information online about the items and services they provide.[[7]](#footnote-8) The regulations compel two disclosures: first, a hospital must make public a “machine-readable file” that contains the standard charges for all items and services.[[8]](#footnote-9) If different hospital locations operating under the same license have different standard charges, each location must make their charges public.[[9]](#footnote-10) Next, to help consumers estimate the cost of using the hospital,[[10]](#footnote-11) the hospital must provide a consumer friendly list of “shoppable services” written in plain language.[[11]](#footnote-12) In this list, a hospital must disclose standard charges for as many of the 70 CMS-specified services the hospital provides, along with the hospital’s additional services, for a total of at least 300 shoppable services.[[12]](#footnote-13) For this shoppable services list, the hospital retains discretion as to how best format the information.[[13]](#footnote-14)

 Both disclosures require an item or service’s description, payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash price;[[14]](#footnote-15) the machine readable file must also contain gross charges.[[15]](#footnote-16) This information must be publicly available on the internet, prominently displayed, and easily accessible.[[16]](#footnote-17) The hospital must update these disclosures at least once per year and clearly state when it completed the update. [[17]](#footnote-18) Notably, CMS finalized an amendment that went into effect January 1, 2022, that prohibits certain activities that present barriers to access to the machine-readable file, specifically requiring that the machine-readable file be accessible to automated searches and direct downloads.[[18]](#footnote-19)

* + 1. ***Health Plan Price Transparency***

In addition to Hospital Price Transparency, as of July 1, 2022, most group health plans and issuers of group or individual health insurance must post pricing information for covered items and services – this information can be used by third parties, such as researchers and app developers, to help consumers better understand costs associated with their health care.[[19]](#footnote-20) The requirements are being rolled out in three stages: the first stage requires most group health plans and issuers of group or individual health insurance to provide machine-readable files with in-network rates (rates for all covered items and services between the plan or issuer and in-network providers) and allowed amounts for, and billed charges from, out-of-network providers.[[20]](#footnote-21) The second stage, which went into effect on January 1, 2023, requires plans and issuers to provide an internet-based price comparison tool (also available by phone or in paper form on request) which allows individuals to receive estimates of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for 500 items and services.[[21]](#footnote-22) In 2024, the last stage will go into effect, which requires an internet-based price comparison tool that allows individuals to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for all items and services.[[22]](#footnote-23)

* + 1. ***Compliance with the Federal Rules***

Beginning January 1, 2021, CMS began auditing a sample of hospitals for compliance in addition to investigating complaints submitted online to CMS and reviewing analyses of noncompliance.[[23]](#footnote-24) Hospitals that are noncompliant may be subject to civil monetary penalties.[[24]](#footnote-25) Similarly, beginning July 1, 2022, CMS began enforcing the applicable price transparency requirements for health plans and issuers. For those subject to CMS’s enforcement authority and do not comply, CMS may take several enforcement actions, including requiring corrective actions and/or imposing a civil money penalty up to $100 per day, adjusted annually under 45 CFR part 102, for each violation and for each individual affected by the violation.[[25]](#footnote-26)

According to a September 2022 article in Health Affairs, the leading journal of health policy thought and research, hospitals have been slow to comply with the federal transparency rules.[[26]](#footnote-27) Between July and September 2021, fewer than 6 percent of hospitals had disclosed prices as required, and hospitals with higher revenues and in highly consolidated markets were “found to be more likely to flout the law.”[[27]](#footnote-28) And even when hospitals have complied with the rules, experts have found the data to be “consistently inconsistent” in terms of how data elements are defined and displayed, making it difficult for third parties to make connections across hospitals and payers.[[28]](#footnote-29) As a result, CMS issued several pieces of technical guidance to insurers before the rules applicable to health plans went into effect – insurers that fail to comply with health plan transparency rules will face fines of around $100 per violation, per day, per affected enrollee, which can quickly add up to larger fines than those faced by hospitals.[[29]](#footnote-30) Initial reports suggest that most insurers have complied with the rule’s technical requirements, but the data files posted are “largely inaccessible and indecipherable to anyone without access to a supercomputer.[[30]](#footnote-31)

* 1. **Federal and State Tax Reporting Requirements for Nonprofit Hospitals**

Hospitals are granted property tax exemptions on grounds that they provide significant amounts of charitable care and community benefits while serving as a public good. To receive a federal tax exemption, the Internal Revenue Service (IRS) requires not-for-profit hospitals to report their community benefit activities on IRS Form 990, Schedule H.[[31]](#footnote-32)

At the state level, New York law exempts from taxation real property owned by nonprofit corporations that are “organized or conducted exclusively” for charitable or hospital purposes, and not for “private inurement.”[[32]](#footnote-33) Under § 420-a of the New York Real Property Tax Law, real property “owned by a corporation or association organized or conducted exclusively for . . . hospital . . . purpose . . . shall be exempt from taxation as provided in this section.”[[33]](#footnote-34) To obtain an exemption, a nonprofit organization must complete the application provided by the NYC Department of Finance.[[34]](#footnote-35) Further, New York Public Health Law requires nonprofit hospitals to develop publicly available annual reports that describe each hospital’s performance in meeting the healthcare needs of the community.[[35]](#footnote-36)

1. **LEGISLATION**
	1. **Int. 844**

Int. 844 would establish an Office of Healthcare Accountability. This office would audit city expenditures on employee-related health care costs, and make recommendations on how to lower these costs. It would also be required to create a publicly accessible website that provides information on the costs of hospital procedures and summarizes the cost transparency of each hospital. Finally, it would also be required to, where feasible, report on the factors external to hospitals such as the operating and profit margin of major insurance providers.

* 1. **Preconsidered Res. No.**

This resolution calls on the New York State legislature to pass, and the Governor to sign, legislation to create an independent Commission to oversee hospital services pricing for the purpose of increasing access to hospital services, promoting financial stability for hospitals, and lowering healthcare costs for New Yorkers.

1. **CONCLUSION**

At the hearing, the Committees look forward to hearing from DOHMH, H+H, and interested stakeholders, such as Greater New York Hospital Association (GNYHA) and 32BJ, as well as advocates and other interested parties about how the legislation would impact hospital operations, as well as provider and patient experiences.

Int. No. 844

By Council Members Menin, Schulman, Narcisse, Abreu, Brannan, De La Rosa, Stevens, Bottcher, Feliz, Ung, Williams, Sanchez, Krishnan, Dinowitz, Hanks, Ariola, Velázquez, Louis, Hanif, Marte, Lee, Avilés, Ossé, Salamanca, Riley, Cabán, Joseph, Brewer, Gutiérrez, Brooks-Powers, Restler, Moya, Richardson Jordan, Hudson, Ayala, Nurse, Gennaro, Won, Farías, Powers, Paladino, Vernikov, Kagan and the Public Advocate (Mr. Williams) (by request of the Manhattan, Queens, Brooklyn and Bronx Borough Presidents)

A Local Law to amend the New York city charter, in relation to establishing an office of healthcare accountability

Be it enacted by the Council as follows:

Section 1. Section 20-m of chapter 1 of the New York city charter, as added by local law number 164 for the year 2021, is renumbered section 20-o.

§ 2. Chapter 1 of the New York city charter is amended by adding a new section

20-p to read as follows:

§ 20-p. Office of healthcare accountability. a. Definitions. For purposes of this section, the following terms have the following meanings:

Director. The term “director” means the director of healthcare accountability.

Office. The term “office” means the office of healthcare accountability.

b. Establishment of office. The mayor shall establish an office of healthcare accountability. Such office may be established as a standalone office or within any office of the mayor or within any department. Such office shall be headed by a director of healthcare accountability, who shall be appointed by the mayor or, if the office is established within an agency other than the office of the mayor, by the head of such agency.

c. Powers and duties. The director shall have the power and duty to:

1. Provide recommendations to the mayor, council, comptroller, or trustees of the city pension systems regarding healthcare and hospital costs, including, but not limited to, the proportion of healthcare costs spent on hospital care;

2. Audit city expenditures on health care costs for city employees, city retirees, and their dependents;

3. Provide, on the office’s website in a simplified and publicly accessible format, information on the costs of hospital procedures. Such information shall be based on any publicly available information relating to the cost of hospital procedures, including disclosures required pursuant to state and federal law, and shall be formatted in a way to allow for comparisons between procedure costs for specific hospitals; and

4. Provide on the office’s website a summary of the cost transparency of each hospital located in the city, categorizing each hospital as very transparent, satisfactory, or not transparent. Such summary shall be updated at least annually and shall be based on the office’s assessment of the information that each hospital has disclosed relating to the cost of hospital procedures, including:

(a) Whether such disclosures comply with the requirements of state and federal law; and

(b) Whether such disclosures were provided within the time period required by state and federal law.

d. Reporting. One year from the effective date of the local law that added this section and annually thereafter, the director shall submit to the mayor, the speaker of the council, and the attorney general of the state of New York, and shall post conspicuously on the office’s website, a report detailing the pricing practices for hospital systems in the city of New York. Such report shall include, but not be limited to, the following:

1. A summary of any audits conducted pursuant to paragraph 2 of subdivision c of this section, including the costs of hospital procedures paid for by the city disaggregated by hospital;

2. A summary of prices charged for hospital procedures disaggregated by:

(a) Hospital;

(b) Type of procedure, and;

(c) To the extent available, the average rate of reimbursement received by the hospital from each health insurance provider or other payer for each procedure;

3. A summary of each hospital’s level of transparency pursuant to paragraph 4 of subdivision c of this section;

4. To the extent available, a breakdown of each major insurance provider’s and other payer’s profit margins, employee headcounts, overhead costs, and executive salaries and bonuses; and

5. To the extent available, a summary of each hospital’s community benefit information as publicly reported on the Internal Revenue Service’s Form 990, Schedule H, as required pursuant to section 501(r) of the Internal Revenue Service code, and each hospital’s publicly available implementation report regarding the hospital’s performance in meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved, as required pursuant to section 2803-l(3) of the public health law.

§ 3. This local law takes effect 120 days after it becomes law.

SOS, JGP, NAW, NAB

LS #8621, 9141, 10286, 10508, 10509

11/30/22 11:30 am

Preconsidered Res. No.

Resolution calling on the New York State legislature to pass, and the Governor to sign, legislation to create an independent Commission to oversee hospital services pricing for the purpose of increasing access to hospital services, promoting financial stability for hospitals, and lowering healthcare costs for New Yorkers.

By Council Member Menin

Whereas, Hospitals across New York State (NYS) have wide service price variations for the same procedures despite similarities in hospital size, range of services offered, teaching designation, and patient population health; and

Whereas, A 2016 Gorman Actuarial report examining hospital service price and reimbursement rate differences in NYS found that higher-priced hospitals in Downstate, Buffalo, and Albany were 1.5 to 2.7 times more expensive than lower-priced hospitals in the same regions; and

Whereas, Hospital service price variations can be attributed to the NYS Health Care Reform Act of 1996 (HCRA), which removed state-regulated hospital service price controls and allowed hospitals and private insurers to negotiate reimbursement rates; and

Whereas, Although the HCRA was created to promote financial sustainability of community hospitals and maintain access to hospital care for all New Yorkers through marketplace competition, it caused many community hospitals to shutter due to their lack of market leverage; and

Whereas, According to the Gorman Actuarial report, regardless of an individual hospital’s size or market share, hospitals that are part of a hospital system with a large market share are generally higher-priced due to the power of the hospital system in contract negotiations with insurers; and

Whereas, As a result, the price of a procedure depends on the type of insurance an individual has and the hospital they go to; and

Whereas, For example, the average cost of a colonoscopy without insurance is $895, but for a covered individual it could cost as much as $2,200 depending on the individual’s insurance plan; and

Whereas, Similarly, an MRI scan without insurance costs $446 within the Mount Sinai Health System, while at New York-Presbyterian Hospital, the same procedure costs approximately

$7,356; and

Whereas, When comparing private insurers’ hospital service price rates with Medicare rates in over 3,000 hospitals across the United States, a 2021 RAND Corporation study found that overall, private insurers paid hospitals over 240 percent more than Medicaid for the same procedures; and

Whereas, A 2022 report by the SEIU 32BJ Health Fund demonstrated that the Fund had been charged more than 300 percent of Medicare rates by private hospital systems; and

Whereas, The Gorman Actuarial report also discovered that among hospitals in the Downstate region, those hospitals with more Medicare and Medicaid patients collected lower payments from private insurers than hospitals serving fewer such patients, calling into question the assumption that hospitals bill higher reimbursement rates for privately insured patients to offset low reimbursement rates for Medicare and Medicaid patients; and

Whereas, New York City government (City) is the biggest consumer of private health insurance in NYS; and

Whereas, In Fiscal Year 2021, the City spent approximately $9.5 billion to pay the cost of health insurance covering approximately 1.25 million people, paying an estimated $1.2 billion in excess for comparable health insurance packages offered by 1199 and 32BJ of the Service Employee International Union, according to Center for New York City Affairs; and

Whereas, In an effort to regulate hospital service prices and induce sustainable hospital growth, the Maryland State legislature established an independent Health Services Cost Review Commission (HSCRC) in 1971; and

Whereas, The HSCRC is comprised of 7 volunteer commissioners with broad healthcare background and expertise; and

Whereas, The HSCRC has authority to regulate hospitals with the following goals: 1) constrain hospital costs; 2) ensure access to hospital care for all citizens; 3) improve equity and fairness of hospital financing; 4) provide for hospital financial stability; and 5) promote hospital and healthcare pricing transparency by holding stakeholders accountable; and

Whereas, Since its formation, the HSCRC has created many programs that have supported the success of Maryland’s hospital system; and

Whereas, One such program is Maryland’s All-Payer Rate Setting System, which saved the state over $796 million in Medicare expenses in 2019 while ensuring identical service prices across all public and private hospitals in the state; and

Whereas, An independent state regulatory body like the HSCRC could be established in NYS to ensure fair hospital pricing, sustainable hospital financing, and equitable hospital access for all New Yorkers; now, therefore, be it

Resolved, That the Council of the City of New York calls on the New York State legislature to pass, and the Governor to sign, legislation to create an independent Commission to oversee hospital services pricing for the purpose of increasing access to hospital services, promoting financial stability for hospitals, and lowering healthcare costs for New Yorkers.

LS # 11662 2/13/23 MB

1. Centers for Medicare & Medicaid Services, <https://www.cms.gov/>. [↑](#footnote-ref-2)
2. [Hospital Price Transparency | CMS](https://www.cms.gov/hospital-price-transparency) [↑](#footnote-ref-3)
3. The Public Health Service Act was enacted as part of the Affordable Care Act and updated Medicare payment policies to require that “each hospital operating within the United States, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary), a list of hospital’s standard charges for items and services provided by hospitals.” <https://www.sihd.org/affordable-care-act-price-list-2718-e>. CMS provided guidance for implementation and stated that hospitals are required to make the list of their standard charges, or their policies for public access to the list, available upon inquiry. *Id*. [↑](#footnote-ref-4)
4. Centers for Medicare and Medicaid Services, *Hospital Price Transparency: Frequently Asked Questions,* <https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf> [↑](#footnote-ref-5)
5. *Id*. [↑](#footnote-ref-6)
6. *Id*. [↑](#footnote-ref-7)
7. *Supra* note 2. [↑](#footnote-ref-8)
8. 45 C.F.R. § 180.40(a). [↑](#footnote-ref-9)
9. *Id.* § 180.50(a)(2). [↑](#footnote-ref-10)
10. *Id.* § 180.60(a)(2)(ii). [↑](#footnote-ref-11)
11. *Id.* §§ 180.50(b)(1); 180.40(b). [↑](#footnote-ref-12)
12. *Id.* § 180.60(a)(1). “If a hospital does not provide 300 shoppable services, the hospital must make public the [standard charges] for as many shoppable services as it provides.” *Id.* 180.60(a)(1)(ii). [↑](#footnote-ref-13)
13. *Id.* § 180.60(c). [↑](#footnote-ref-14)
14. *Id.* §§ 180.50(b)(3)-(6); 180.60(b)(3)-(6). [↑](#footnote-ref-15)
15. *Id.* § 180.50(b)(2). [↑](#footnote-ref-16)
16. *Id.* §§ 180.50(d)(1)-(3); 180.60(d)(1)-(3). Accessing the information also cannot require a user to pay, make an account, enter a password, or enter personal identifying information. *Id.* § 180.60(d)(2)(i)-(iii). [↑](#footnote-ref-17)
17. *Id.* §§ 180.50(e); 180.60(e). [↑](#footnote-ref-18)
18. *Supra* note 4. [↑](#footnote-ref-19)
19. *Supra* note 2. [↑](#footnote-ref-20)
20. [CMS | Healthplan Price Transparency](https://www.cms.gov/healthplan-price-transparency). [↑](#footnote-ref-21)
21. *Id*. By plan or policy years beginning on or after January 1, 2023, most group health plans and issuers of group or individual health insurance coverage are required to disclose personalized pricing information for all covered items and service to their participants, beneficiaries, and enrollees through an online consumer tool, by phone or in paper form upon request. *Id*. Cost estimates must be provided in real-time based on cost-sharing information that is accurate at the time of the request. *Id*. [↑](#footnote-ref-22)
22. *Id*. [↑](#footnote-ref-23)
23. [2020-12-18-MLNC-SE | CMS](https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-12-18-mlnc-se) [↑](#footnote-ref-24)
24. [2020-12-18-MLNC-SE | CMS](https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-12-18-mlnc-se). Effective January 2, 2022, the Civil Monetary Penalties (CMP) for hospital noncompliance increased the minimum CMP to $300/day (for smaller hospitals with a bed count of 30 or fewer) and a penalty of $10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. <https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf>. Under this approach, for a full calendar year of noncompliance, the minimum total penalty would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital. This retains the current penalty amount for small hospitals, increases the penalty amount for larger hospitals, and affirms the Biden Administration’s commitment to enforcement and public access to pricing information. *Id*. [↑](#footnote-ref-25)
25. [CMS | Healthplan Price Transparency](https://www.cms.gov/healthplan-price-transparency/plans-and-issuers) [↑](#footnote-ref-26)
26. Maanasa Kona, Sabrina Corlette, *Hospital and Insurer Price Transparency Rules Now in Effect but Compliance is Still Far Away* (Health Affairs, Sept. 12, 2022), <https://www.healthaffairs.org/content/forefront/hospital-and-insurer-price-transparency-rules-now-effect-but-compliance-still-far-away>. [↑](#footnote-ref-27)
27. *Id.* [↑](#footnote-ref-28)
28. *Id.* [↑](#footnote-ref-29)
29. *Id.* [↑](#footnote-ref-30)
30. *Id.* [↑](#footnote-ref-31)
31. I.R.S. Code § 501(r). According to the IRS, in the context of operating a tax-exempt hospital, it is not enough for a hospital to state that it operates exclusively to promote health – they must also demonstrate that it “operates to promote the health of a class of persons that is broad enough to benefit the community,” also known as the “community benefit standard.” See <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>. [↑](#footnote-ref-32)
32. N.Y. Real Property Tax Law § 420-a. Under state law, hospitals are part of the “mandatory class” of tax exempt properties, meaning localities must exempt such property pursuant to the state law. [↑](#footnote-ref-33)
33. N.Y. Real Property Tax Law § 420-a(1)(a). [↑](#footnote-ref-34)
34. <https://www.nyc.gov/site/nfp/index.page>. On the application, organizations must disclose which portions of their property are used for exemptible purposes, and which portions have no exempt use and are not actively being contemplated for an exempt use, as well as those portions leased to a commercial, non-exempt organization. *Id*. [↑](#footnote-ref-35)
35. N.Y. Pub. Health Law § 2803-I(3). [↑](#footnote-ref-36)