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THE COUNCIL

COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION

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December 12, 2019

Oversight: Rising Health Care Costs

I. Introduction[1]

On December 12, 2019, the Committee on Health, chaired by Council Member Mark Levine, and the Committee on Hospitals, chaired by Council Member Carlina Rivera, will hold a hearing on rising costs of health care in New York City. The Committees plan to discuss surprise medical bills and their impacts on patients and health care costs. Witnesses invited to testify include representatives from voluntary hospitals, advocacy organizations, labor unions, and community-based organizations.

Previously, the Committee held a related hearing in November 2018 on the topic of cost discrepancies between New York City's voluntary hospitals.[2]

II. Background

Data shows that the United States spends more on health care than any other country in the world.[3] Our increased costs are caused by a multitude of factors, including inflated prices for health care goods and services.[4] The American medical system attends to its own profits, with many costs for services largely based on prices completely unregulated by the government, leaving insurance companies and providers to set rates that has left the country spending nearly

[1] It should be noted for this committee report that most of the data is nationally-gathered rather than New York City-specific data.
[2] *See* Nov. 19, 2018 hearing, "Oversight - Cost Disparities between New York City's Voluntary Hospitals," New York City Council website, available at https://nyc.legistar.com/MeetingDetail.aspx?ID=651532&GUID=329A96B8-C5D2-4A28-AC7D-7B917B51AAD4&Options=info&Search=.
[3] *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, Health Affairs (2003) available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.3.89
[4] *Id.*

one-fifth of its gross domestic product on health care.[5] Health care pricing is opaque, with costs dependent upon where a service is rendered and by whom.[6]

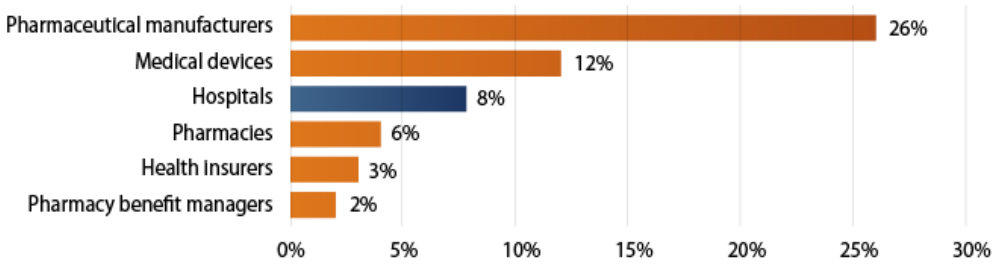
It is estimated that health care expenditures reached $11,212 per person in 2018,[7] and that costs will rise by more than 5.5 percent annually over the next decade.[8] Partly due to major national mergers and acquisitions, and the subsequent conglomeration of hospital systems throughout the country, hospitals now own a substantial share of the health care market, receiving $1 out of every $3 spent on health care.[9] It is projected that the United States will spend $1.3 trillion dollars on just hospital care in 2019, with hospitals claiming a profit-to-revenue margin of 8 percent, which is higher than the reported margins for some industries related to pharmacy benefits and health insurances (see figure below).[10]

[5] Rosenthal, E., *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*, Penguin Random House, 2017.
[6] *Id.*
[7] "US Health Care Costs Skyrocketed to $3.65 Trillion in 2018," Fortune, Feb. 21, 2019, available at https://fortune.com/2019/02/21/us-health-care-costs-2/.
[8] "The High Price of Hospital Care," Center for American Progress, June 26, 2019, available at https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/, citing Centers for Medicare and Medicaid Services, "NHE Fact Sheet," available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.
[9] *Id.* citing Andrea M. Sisko and others, "National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth," *Health Affairs* 38 (3) (2019).
[10] *Id.*

FIGURE 2

The hospital industry is more profitable than the insurance or pharmacy industry

Profit margins in the health care sector by industry



Note: Percentages have been rounded to the nearest whole number. Data points in the table come from multiple sources and do not all cover the same time period.

Sources: Neeraj Sood and others, "The Flow of Money Through the Pharmaceutical Distribution System" (Los Angeles: University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, 2017), available at https://healthpolicy.usc.edu/wp-content/uploads/2017/06/USC_Flow-of-MoneyWhitePaper_Final_Spreads.pdf; American Hospital Association, TrendWatch Chartbook 2018: Table 4.1: Aggregate Total Hospital Margins and Operating Margins; Percentage of Hospitals with Negative Total Margins; and Aggregate Non-operating Gains as a Percentage of Total Net Revenue, 1995 – 2016" (Chicago: 2018), available at https://www.aha.org/system/files/2018-05/2018-chart-book-table-4-1.pdf; U.S. Government Accountability Office, "Medical Device Companies: Trends in Reported Net Sales and Profits Before and After Implementation of the Patient Protection and Affordable Care Act" (Washington: 2015), available at https://www.gao.gov/assets/680/671094.pdf.

CAP

Hospital costs and expenditures are explained by a multitude of factors, including local input costs, administrative costs, utilization, populations served, and medical practices and styles; however, according to data gathered from the Institute of Medicine, price variation is the most significant factor in determining geographic variation of hospital expenditures among people with private insurance.[11] Prices for patients also largely vary based on their form of health insurance. As a result of the Affordable Care Act, insurers must use at least 80 percent to 85 percent of every premium dollar on patient care.[12] Insurers are incentivized to offer larger payouts to competitive hospital systems that provide care to many of their enrollees, then passing on increased costs to patients who pay higher premiums and thus increase their profits.[13]

[11] *Id.* citing Institute of Medicine, "Variation in Health Care Spending: Target Decision Making, Not Geography" (Washington: 2013), available at https://www.ncbi.nlm.nih.gov/books/NBK201637/.
[12] Rosenthal, E., *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*, Penguin Random House, 2017.
[13] *Id.*

Increased health care costs have drastically impacted the way patients access care. In 2017, about 1 in 10 adults reported that they delayed or did not get care because of costs.[14] Individuals who require more care and who are uninsured have more difficulty accessing care due to cost, leaving those who are most sick and vulnerable at the most risk.[15] Those with health insurance also face higher costs because of the inflated health care system, with health care spending for a family of four with employer coverage topping $22,000 on average in 2018.[16]

III. Rising Health Care Costs and Surprise Medical Billing

Rising Health Care Costs

As mentioned above, the rise in health care costs is a multifaceted and complex issue, with many direct and indirect causes. Three of the most significant determinants in the rise of health care costs are the rising costs of prescription medicines, insurance premiums, and hospital billing.

Prescription Medicine

The cost of prescription drugs has risen significantly over the last decade. According to National Health Expenditure Data, the United States spent $236 billion on prescription drugs in 2007, and $333 billion on prescription drugs in 2017.[17] This is an increase of more than 40 percent over a decade, with the largest increasing occurring in 2014, with a 13.1 percent increase

[14] Claxton, G., Sawyer, B., & Cox, C., *How does cost affect access to care?*, Health System Tracker, January 22, 2019, available at https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-start
[15] *Id.*
[16] Rae, M., Copeland, R., & Cox, C., *Tracking the rise in premium contributions and cost-sharing for families with large employer coverage*, Health System Tracker, August 14, 2019, available at https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/
[17] "Why Are Prescription Drug Prices Rising," US News, Feb. 6, 2019, available at https://health.usnews.com/health-care/for-better/articles/2019-02-06/why-are-prescription-drug-prices-rising.

in just that year.[18] Similarly, prescription pharmaceutical sales increased from $500 billion to $700 billion between 2005 and 2015, with profits rising 18 percent in the same time period.[19] While research and development (R&D) are often cited by pharmaceutical companies as the catalyst for high prescription prices, there have notably been no significant increases in R&D spending during the same time period where prescription pharmaceutical prices, sales, and profits increased.[20] Worldwide, R&D spending only increased from $82 billion to $89 billion over the same time period.[21]

This increase in costs has occurred because of both expensive new drugs, and because of significant increases in existing drugs. For example, the Food and Drug Administration recently approved Orkambi, a therapy designed to treat the most common mutation of Cystic Fibrosis, which has an annual list price of $259,000.[22] Similarly, Sovaldi, a drug to treat Hepatitis C virus, which was approved in 2013, costs $84,000 for a 12-week treatment.[23] For prescription drugs that have been on the market for a longer time period, there have been very significant increases in cost. For example, Insulin medications, which are needed for individuals with Type 1 Diabetes, have seen drastically rising costs, reaching an average of $5,705 annually in 2016, which is nearly double what it cost just four years before in 2012.[24] Lyrica, a drug to treat pain relating to fibromyalgia and which has been on the market since 2007, saw a 51 percent increase

[18] "The Facts about Rising Prescription Drug Costs," The Campaign for Sustainable Rx Pricing, available at https://www.csrxp.org/wp-content/uploads/2016/04/CSRxP_Facts-of-Rising-Rx-Prices.pdf.
[19] "Why Are Prescription Drug Prices Rising," US News, Feb. 6, 2019, available at https://health.usnews.com/health-care/for-better/articles/2019-02-06/why-are-prescription-drug-prices-rising.
[20] *Id.*
[21] *Id.*
[22] "The Facts about Rising Prescription Drug Costs," The Campaign for Sustainable Rx Pricing, available at https://www.csrxp.org/wp-content/uploads/2016/04/CSRxP_Facts-of-Rising-Rx-Prices.pdf.
[23] *Id.*
[24] *See* "Struggling to Stay Alive: Rising Insulin Prices Cause Diabetics to Go to Extremes," USA Today, Mar. 27, 2019, available at https://www.usatoday.com/in-depth/news/50-states/2019/03/21/diabetes-insulin-costs-diabetics-drug-prices-increase/3196757002/.

over three years, ensuring that the drug was one of Pfizer's "best sellers" in 2014 and 2015.[25] In fact, Pfizer raised prices on 133 of its products in 2016 alone, and more than three-quarters of those increases were 10 percent or more.[26]

A few explanations for these significant increases include manufacturer price hikes, the presence of prescription benefit managers (who act as "middlemen" between pharmaceutical companies and those who pay for drugs), a lack of transparency surrounding drug pricing, overbroad patent protections for pharmaceutical companies which lead to a lack of competition, and mergers and acquisitions within the pharmaceutical industry. Whatever the causes, however, it is clear that without broad federal oversight and regulation, the country can anticipate a steady and significant rise in the costs of prescription drugs, which will continue to lead to a lack of patient access and a danger to public health.

Insurance Premiums

Another contributing factor to the rising costs of health care is the rising cost of health insurance premiums, particularly in the last three years. Since 2016, employer-based health insurance premiums rose 4.9 percent for single plans and 5.1 percent for family plans.[27] By late 2019, the average employer-based health insurance premium for family coverage climbed over $20,000.[28] This means that health insurance premiums have risen by 54% over the last decade, at a much faster rate of increase than inflation or average wage increases.[29]

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[25] *Id.*
[26] *Id.*
[27] "Trends in Employer Health Care Coverage, 2008–2018," The Commonwealth Fund, Nov. 21, 2019, available at https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.
[28] "2019 Employer Health Benefits Survey," Kaiser Family Health, Sep. 25, 2019, available at https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.
[29] "Health Insurance Premiums Increased More than Wages this Year," CNBC, Sep. 26, 2019, available at https://www.cnbc.com/2019/09/26/health-insurance-premiums-increased-more-than-wages-this-year.html.

In addition to the increase in health care premiums, deductibles and out-of-pocket expenses are also increasing for the average non-elderly American.[30] Put together, this means that over the last decade, the average American is paying more for less health insurance coverage. It is understandable, then, that 61% of Americans polled say that they are worried about increases in premiums or being responsible for a greater portion of their medical expenses.[31] This is especially true as experts predicts that premiums will only continue to rise in the upcoming years, unless broad federal changes are made.

Hospitals

There has been recent news coverage surrounding rising, disparate healthcare costs between hospitals.[32] As mentioned above, the consolidation of hospital systems and medical practices across the country has led to reduced market competition and soaring prices for patients utilizing hospitals. According to reports from UnitedHealth Group, inpatient hospital prices rose 4.5 percent annually every year between 2013 and 2017, even though insured patient use of inpatient care dropped 5 percent in that same time period.[33] The rate of rising inpatient pricing for hospitals (4.5 percent) was nearly twice as much as the rise of physician prices for inpatient services (2.5 percent) during that same time period.[34] More specifically, hospital prices rose faster annually than physician prices during that same five-year period for some inpatient services such as hypertension (6.5 percent vs. 1 percent), vaginal birth (6 percent vs. 2 percent), cesarean section (5.5 percent vs. 2 percent), coronary bypass (6 percent vs. 1.5 percent), and

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[30] *Id.*
[31] "61% of Americans Are Worried About Rising Health Care Premiums," Fortune, Dec. 11, 2018, available at https://fortune.com/2018/12/11/health-care-premium-cost-poll/.
[32] *See, e.g.*, "Beyond Your Rising Health-Care Bills: Secret Hospital Deals that Squelch Competition," Wall Street Journal, Sept. 18, 2018.
[33] "UnitedHealth Group report targets rising hospital prices," Health Care Dive, Aug. 14, 2019, available at https://www.healthcaredive.com/news/unitedhealth-group-report-targets-rising-hospital-prices/560793/
[34] *Id.*

appendectomy (7.5 percent vs. 0 percent);[35] this implies that it is hospitals, and not physicians, pharmaceuticals, insurance companies, or medical providers that are driving the rise in costs. The total cost of inpatient services for privately-insured consumers exceeded $200 billion in 2018.[36]

Surprise Medical Billing

One of the most discussed aspects of the costs of hospital care is surprise medical billing. Surprise billing typically occurs when an insured person receives an unanticipated medical bill for an out-of-network emergency service or from an out-of-network provider, "either because the option of in-network care is not available or because the out-of-network provider delivers care in an in-network facility without the consumer's knowledge."[37] Notably, surprise billing can occur for emergency care and for planned inpatient care. In both situations, consumers may be responsible for the full bill, or for the balance between the billed amount and what their insurance plan pays for out-of-network care.[38] These bills can often be exorbitant and difficult to understand, and can leave consumers with significant medical debt[39] or subject to predatory bill collectors.[40] Yet, surprise billing is extremely common for many health care consumers. For example, for consumers of large employer plans, it is reported that 18 percent of all emergency visits and 16 percent of in-network hospital stays had at least one out-of-network charge associated with the care in 2017; in New York State, these rates were 28 percent and 33 percent,

[35] *Id.*
[36] *Id.*
[37] "Teasing Apart the Threats to the Surprise Billing Debate," A FAIR Health Brief, Mar. 2019.
[38] *See generally*, "Surprise Billing: Another Healthcare Market Failure," Forbes, Jun. 10, 2019, available at https://www.forbes.com/sites/joshuacohen/2019/06/10/surprise-billing-another-healthcare-market-failure/#5fe51b0e399e.
[39] *Id.*
[40] *See, e.g.*, "This Doctors Group Is Owned by a Private Equity Firm and Repeatedly Sued the Poor Until We Called Them," ProRepublica, Nov. 27, 2019, available at https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top.

respectively.[41] Due to the prevalence of surprise billing, two-thirds of Americans say they are either "very worried" (38 percent) or "somewhat worried" (29 percent) about being able to afford unexpected medical bills, while 39 percent of insured non-elderly adults said they received a surprise medical bill in the past year, 13 percent of whom say the unexpected costs were $2,000 or more.[42] Surprise billing impacts not only the consumers who are saddled with paying them, but also all insured individuals who pay higher premiums as a result.[43]

There has been some New York State legislative action to address this issue. In 2015, the State passed the Out-of-Network Law (OON Law) to protect consumers from surprise bills when services are performed by an out-of-network provider at a participating hospital, or for all services performed during an emergency.[44] The OON Law establishes an Independent Dispute Resolution (IDR) process wherein consumers may submit a surprise billing dispute through a portal on the State Department of Financial Service's (DFS) website.[45] The IDR entity then determines whether the provider's fee or health plan's payment is reasonable, while patients are held faultless.[46] State guidance says that arbiters should use the 80th percentile of billed charges ("list prices" or "sticker prices") in determining reasonableness.[47]

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[41] "An Examination of Surprise Medical Bills and Proposals to Protect Consumers From Them," Health System Tracker, Oct. 16, 2019, available at https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/.
[42] *Id*.
[43] *See, e.g.*, "New York's Very Expensive Surprise Medical Billing Solution," Axios, Oct. 25, 2019, available at https://www.axios.com/surprise-medical-bills-new-york-law-ac7772ac-6779-4526-a1c0-9a63908757ef.html.
[44] Part H of Chapter 60 of the Laws of 2014.
[45] *See* "Surprise Medical Bills and Emergency Services," Department of Financial Service's Website, available at https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills.
[46] *Id*.
[47] *See* "Out-of-Network (OON) Law FAQs," Department of Financial Service's Website, available at https://www.dfs.ny.gov/apps_and_licensing/health_insurers/outofnetwork_law_FAQs.

The State's IDR process was implemented in March 2015, and 2,595 decisions have been rendered between 2015 and 2018.[48] According to the DFS, since implementation of the OON Law, out-of-network billing in New York State went down 34 percent, and in-network emergency physician payments went down by 9 percent.[49] The OON Law is estimated to have saved consumers over $400 million.[50] However, one glaring problem with the State's OON guidance is that the list or sticker prices in hospitals tend to be significantly higher than the negotiated rates that insurers pay for in-network care.[51] Although DFS estimates cost-savings from the OON Law, it also acknowledges that the average payment amount decided through arbitration is 8 percent higher than the 80th percentile of charges,[52] which means that medical providers are still winning in these arbitrations, and that insured individuals will still pay increased premiums to compensate for any money lost due to the OON Law. But, legislative efforts to set a capped rate for what insurers would pay providers have been met with great opposition from hospitals, who claim that such a cap would erode their negotiating power with insurance companies, and accordingly would leave patients at risk.[53]

Under current federal law, states are preempted from: requiring employer plans to cover out-of-network surprise bills, requiring employer plans to apply in-network cost sharing to out-of-network surprise bills, and requiring employer plans to settle payment disputes with out-of-

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[48] "Report on the Independent Dispute Resolution Process," New York State Department of Financial Services, Sept. 2019.
[49] *Id.*
[50] *Id.*
[51] "New York's Very Expensive Surprise Medical Billing Solution," Axios, Oct. 25, 2019, available at https://www.axios.com/surprise-medical-bills-new-york-law-ac7772ac-6779-4526-a1c0-9a63908757ef.html.
[52] *Id.*
[53] *See, e.g.*, "Hospitals' dog in the surprise billing fight," Axios, Sep. 13, 2019, available at https://www.axios.com/hospitals-doctors-surprise-medical-bills-bff170b4-c508-454e-8d6b-0a7707a830fe.html.

network providers over surprise bills using state-established payment rules or procedures.[54] Additionally, 61 percent of covered workers are covered under self-insured group health plans that are beyond the reach of state regulation.[55] Accordingly, the federal government would need to act to impose comprehensive solutions to the problem of surprise medical billing.

IV. Conclusion

The purpose of this hearing is for the Committees to better understand the rising hospital costs and pricing in New York City, and to better understand surprise billing practices and protections in New York City hospitals. Surprise medical billing is extremely complicated and likely requires federal action to be fully addressed, particularly as hospital costs continue to rise and as states are preempted from taking comprehensive, meaningful action.

[54] This preemption occurs under Employee Retirement Income Security Act of 1974, or ERISA. *See, e.g.*, "An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them," Health System Tracker, Oct. 16, 2019, available at https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/.
[55] *Id.*