COMMITTEE ON HEALTH JOINTLY

WITH COMMITTEE ON HOSPITALS

CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH JOINTLY WITH THE COMMITTEE ON HOSPITALS

December 12, 2019
Start: 10:21 a.m.
Recess: 1:29 p.m.

HELD AT: 250 Broadway-Committee Rm, 14th Fl.

B E F O R E: MARK LEVINE
Chairperson

CARLINA RIVERA
Co-Chair

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

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

Henry Garrido
Executive Director of DC 37

Larry Engelstein
Secretary Treasurer of 32 BJ

Sara Rothstein
Director of the 32 BJ Health Fund

Luchiana Owens
Member of 32 BJ, Cleaner at Commercial Office Building

Yenny Hernandez
Cleaner at Commercial Office Building in Midtown

Andy Title
Assistant Vice President for Government Affairs
At the Greater New York Hospital Association

Leslie Moran
Senior Vice President of the New York Health Plan Association

Elisabeth Benjamin
President for the Health Initiative at the Community Service Society of New York

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

Naysha Diaz
Government Relations Associate at Planned Parenthood of New York City, PPNYC

Patrick Kwan
Senior Director for Advocacy and Communications
For the Primary Care Corporation, PCDC

[gavel]

CHAIRPERSON LEVINE: Good morning everyone and welcome to this joint hearing of the City Council's Health and Hospitals Committees. I'm Mark Levine, Chair of the Health Committee and pleased to be joined by my partner in all thing's health and Co-Chair of this hearing Carlina Rivera. I want to acknowledge we are joined by Council Member Andy Cohen and others who will be joining us shortly. Okay. There is so much which is broken in our health care system but we're here today to focus on one crisis, the crisis of endlessly escalating health care costs. This crisis is impacting our city budget, it's impacting patients, it's impacting workers, it's impacting organized labor and today is about demanding answers and finding solutions to solve this crisis. Last year the United States spent 3.6 trillion dollars on health care, that comes out to an average of over 10,000 dollars per person per year, that is double what comparable countries spend from Switzerland to France to Japan where health care outcomes are as good or better than those in the United States. In fact, costs in America are inflated, largely unregulated and frankly out of

control and in New York State, especially New York City this crisis is even more acute. There are many, many players to blame for this including the pharmaceutical industry where medications for everything from sickle cell disease, hepatitis, life threatening allergies, diabetes, HIV prevention just to name a few have all skyrocketed in price forcing patients often to choose between forgoing necessary treatments or skipping the rent or skipping a meal. Lack of regulation of drug prices has handed big pharma decades long monopolies over life saving drugs that have given them to power… given them the power to charge extortionary costs. Then there are the insurance companies which somehow seem to make billions in profits no matter what happens to the health care economy, every year, billions of profits, profits that only increase while they continue to impose secretive, unfair insurance agreements on the health care system that ultimately hurt patients and the hospitals. When you go in for treatment in a hospital in New York City you have no idea what kind of bill you're going to walk out with, you may walk out with a bill of thousands or tens of thousands of dollars, that which could effect you as a consumer,

that could land you in court, that could hurt your credit history, that could land you in bankruptcy. This is often because patients are slapped with out of network costs even in cases where the hospital itself is in network because there's a tangled web of insure relationships even among providers in the same building. The result of exorbitant fees for patients and the tens of thousands of dollars even sometimes for routine procedures is sadly not a rare occurrence, it's estimated that as much as 28 percent of New Yorkers with large employer coverage will receive a surprise bill at some point after receiving emergency medical care, emergency care, you're not shopping for prices before you go into the emergency room, you are forced to deal with whatever fees are imposed on you. Surprise billing impacts not only the consumers who are saddled with paying with them but also all insured people who in the end, end up paying higher premiums as a result. Fortunately in 2015 New York State passed the out of network law which establishes an independent dispute resolution or IDR process, patients can submit a surprise bill now to the State Department of Financial Services but the law does not apply to all patients or all employers

including several we'll hear from today and it has added significant cost for arbitration and there's a strong argument that it hasn't gone far enough in protecting patients. The endless escalation of health care costs hurts us all, it's seriously impacting the physical health of New York City because of the outside portion of our budget we're now devoting to health care costs, it hurts workers who are forced to use their precious bargaining capital to pay for health care as opposed to wage increases and other benefits and as I described it ultimately hurts patients and we look forward to diving in much deeper into this topic today to get answers and solutions. I'm pleased that we have been joined by Council Member Antonio Reynoso and I want to pass it off to my Co-Chair, Council Member and Chair Carlina Rivera.

COUNCIL MEMBER RIVERA: Thank you so much. Good morning everyone. I am Carlina Rivera, Chair of the Hospitals Committee and I want to thank my colleagues for joining us today and I know we'll be joined by others as the hearing goes on. The American medical system attends to its own profits with many costs for services largely based on prices completely unregulated by the government. Health care

pricing is opaque with costs dependent upon where a service is rendered and by whom. As Chair Levine mentioned data shows that the United States spends more on health care than any other country in the world. In 2018 we spent over 3.6 trillion on health care expenditures meanwhile our health outcomes rank below other similar nations. Although the affordable care act did much to increase access to health insurance for most Americans especially New Yorkers it did very little to impact our inflated health care systems leaving insurance companies and providers to set rates that have left the country spending nearly one fifth of it's gross domestic product on health care. 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, insurers are therefore incentivized to offer larger payouts to hospital systems that provide care to their enrollees then passing on increased costs to patients who in turn pay higher premiums and thus increase insurers profits. Prices for care received at hospitals are also increasing. In 2018 the US spend over one trillion dollars on hospital expenditures alone. The consolidation of hospital systems and medical

practices has led to reduced market competition and soaring prices for patients. There are multiple studies which speak to the enormity of these issues such as a study based in California that found that the cost of an identical procedure ranged from as little as 1,529 dollars to as much as 182,955 dollars within the state. Notably the prices varied more by individual institution than their geographic region. Fluctuating, unpredictable and expensive health care costs have drastically impacted the way patients access care. In 2017 about one in ten adults reported delaying or forgoing care because of costs. Individuals who require more care and who are uninsured have more difficulty accessing care due to costs leaving our more… our most sick and vulnerable with the most risk. Even those with health insurance face higher costs because of our inflated health care system with health care spending for a family of four with employer coverage topping 22,000 dollars on average in 2018. Premiums, deductibles and other cost sharing are simply too expensive and as the price of care increases so will our out of pocket expenses. Today I'm asking why, why have we accepted a health care system that is so expensive people are rationing

their care and medication not based on medical advice yet based on financial need, why do other countries hear of our costs on medical procedures and ask so if you're poor you're dead? Today we will explore this issue through the lens of surprise medical bills which impact nearly one out of every five people who seek emergency care as well as New York State's actions to reduce the incidence of surprise bills. New York State has done a good job protecting patients and today I look forward to hearing from stakeholders about their experience with this law, potential improvements and other ways we can help New Yorkers better afford their care. I look forward to hearing how this law is implemented at the hospital level. Specifically, I want to make sure that all patients are aware of their rights and are receiving the information necessary to make informed decisions. Thank you to everyone present here today and I look forward to hearing from all of you. Thank you.

CHAIRPERSON LEVINE: Thank you so much Chair Rivera. I want to acknowledge we've been joined by fellow health committee members Doctor Mathieu Eugene and Council Member Bob Holden. I would like to call up our first panel which will include Henry

Garrido, Executive Director of DC 37 and we have four representatives from 32 BJ including Larry Engelstein, Yenny Hernandez, Luchiana Owens and Sara Rothstein. I realize we have a small table and… [cross-talk]

COUNCIL MEMBER RIVERA: So, one, one person… for the fifth person if you don't mind we're going to swap you out at the end of the four testimonies just to make sure we can capture all of your faces on the streaming network.

[off mic dialogue]

CHAIRPERSON LEVINE: Okay Mr. Garrido would you like to start us off?

HENRY GARRIDO: Yes, good morning.

CHAIRPERSON LEVINE: Alright.

HENRY GARRIDO: Good morning. Good morning Chairs Levine, Rivera and fellow committee members. My name is Henry Garrido and I'm the Executive Director of District Council 37 which represents over 300,000 New Yorkers who are covered by health insurance and live in the New York City metropolitan area. I want to thank you both for holding this important hearing to discuss the rising costs of health care and hospitalization. I appear

before you today to identify some of the reasons health care costs has skyrocketed for the last decade and to suggest a few ways to bring this unsustainable situation under control. The single factor that has most profound negatively impacted on health care coverage in New York City is the cost of inpatient and outpatient care provided by the city's nonprofit and voluntary hospitals. At the offset I'd like to point out that District Council 37 and our brothers and sisters that make up the municipal labor committee of which I am a Co-Chair, have been doing a part to reduce hospital bills with significant changes of design to our health care system and plans. For example, we have moved non agent… non urgent but essential procedures from hospitals to outpatient centers including for example colonoscopies and infusions, we have changed our insurance co-pay structure to discourage members from utilizing emergency rooms for non-urgent treatment, we have implemented wellness programs including diabetes disease prevention and telehealth programs to in… improve the member's health and prevent hospitalizations, we have looked for and implemented every way to change our member's conduct to relied

upon hospitals for the primary care and lower costs but New York City's nonprofit private hospital systems are not doing the part to contain the costs. The largest five hospital systems that dominate New York City still find ways to increase the cost by seven, eight and ten percent each year. Year after year the costs then are passed on to us as employers, as participants, as labor organizations that provide health care, to New York City's working family. So, why do they do this? Well they do it because they can and they are able… enabled by the complexities of contracts between the cities, the insurers and the hospitals. These contracts create discrepancies that are incomprehensible. A hip replacement procedure can cost 83,000 dollars at one hospital and 56,000 dollars at another hospital and just to note that is not just between hospitals even within the same hospital system, there's a huge discrepancy for the same procedures, for the same providers under the same contract which makes no sense to, to us. Hospitals that serve, serve Medicare and Medicaid patients receive lower prices in the private market while hospitals that serve insured patients have lower… have higher prices. On average higher priced

hospitals in New York metropolitan area are about two and a half times higher than the lowest priced hospitals. It is not necessarily true that the higher cost translates into the best quality of care. Research has shown in New York City's hospital… public hospital provides higher than average quality care even though they are increasingly picking up the cost of treating populations that private hospitals do not. As you all know New York City Health and Hospitals is charged with treating patients regardless of their ability to pay and just because nonprofit, private hospitals charge higher rates that does not necessarily mean their patients receive better treatment. Just this week Governor Cuomo called upon the State Department of Health to investigate the terrible overcrowding and understaffing of Mount Sinai's emergency room. The former head of the hospital department went on record to say Mount Sinai wins top national rankings for such specialty departments as pediatrics, oncology and elective surgery. The, the… it's administrator just figured that the kind of patients who show up for the ER just aren't worth much trouble because the hospital's all likely… are all too likely to lose on

treating them. Adding insult to injury is the fact that hospital special… executive compensation has soared with the cost of care. In 2018 Crain's New York Business reported that the ten top hospital paid CEOs receive combined salary perks and other compensation totaling more than 53 million dollars. At the same time the city and the state also offer hundreds of millions of dollars of tax breaks and I, I want to make an emphasis on this because the city is, is making a major investment into these hospitals expecting results. Currently there are 655 tax exemptions… exempted properties owned by nonprofit private health care facilities totaling 1.7… 1.17 billion dollars, that figure includes hospitals like 106 million dollars in tax exemption for NYU and Columbia Presbyterian, this… nonprofit hospitals are enjoying year after year of surpluses that they need to be receiving tax breaks and hiking costs and more importantly and this is not in testimony, do they show what value they're giving us for the, the exemptions that the city's providing. If these nonprofit hospitals are enjoying these, these tax breaks the question is why does… is the cost continue to hike at the rate that it is higher than the

national average. Finally in the last decade we have seen hospital consolidations resulting in the creation of New York City… in five New York City's mom of health care systems, these networks are creating monopolies which also only adverse… adversely impact patient cost, they call them the five families folks because that's what they are, they negotiate as such and the inference is pretty clear. So, what can we do about this? I'd like to offer four recommendations. First, we would like to conduct an investigation into these private hospitals with high cost services that decline to treat uninsured and under insured, low income and immigrant populations, we'd like the City Council to take the lead on this. That's okay you can cheer. Number two, the city along with the state, must reevaluate its property tax exemptions to private hospital systems that are not willing to treat the same population that can at, at… can least afford the services. Number three, we need to create a stale holder… a stakeholder group that includes labor unions, health care advocates, consumers, health care institutions and insurance providers to discuss the cost and quality of health care. The City Council, number

four, should monitor all hospitals, public and private and health care plans to measure disparities in pricing and care. And I want to say this, it's pretty significant that both public sector unions, the largest and private sector are here despite being in two completely different systems but being affected by the same circumstances. We are partners with BJ but what we have seen across the board is even though we have the city as the employer providing health care spending almost ten billion dollars annually, in spite of the municipal committee coming with two consecutive rounds of negotiations saving 3.4 billion dollars and 2.4 billion dollars respectively we're suffering the same problems in rising costs in hospitals and prescription drugs that you mentioned as our brothers and sisters from the private sector, that is pretty significant and if you speak with anyone of the 152 represented union by the municipal labor committee you're going to find the same results. Our members are scared and they're looking for answers and we're turning to you because we're not getting answers from the hospitals or the insurance companies. So, I am begging you, I don't beg but I am begging you today for the sake of the

health of many people who are suffering between making the decisions of paying rent or going to the emergency room that you look into this today on behalf of the working people. Thank you.

[applause]

[off mic dialogue]

CHAIRPERSON LEVINE: I'll acknowledge while you're preparing, we've been joined by fellow Health Committee member Keith Powers and also Inez Barron who will be moving back and forth between committees.

LARRY ENGELSTEIN: Hi, my name is Larry Engelstein, I'm the Secretary Treasurer of 32 BJ and I really appreciate and… the Committee and Committee Chairs Rivera and Levine for conducting this hearing. As my brother said this is an incredibly important issue for our union, for working class New Yorkers generally, for nonunion workers, for taxpayers and for the health of our community. Our union has over… represents over 85,000 workers in the New York City area, we operate along with our bargaining partners a jointly trusteed health fund that takes in 1.5 billion dollars a year in employer contributions. Maintaining affordable, accessible health care is the

top priority for our members in every bargaining cycle. We have… I have submitted some testimony, but I figured you guys could read it and I would just talk about the central issues so if you bear with me. Our plan is a self-insured plan, we… which means that every claims dollar that we pay is a dollar that we negotiate at the bargaining table with our employers to contribute into the fund. We have access to the providers through insurance companies such as Empire who negotiate deals separately with each of the major hospitals and they administer our claims through those contracts. Because of the incredible rising health care inflation maintaining our health care benefits has become the central issue in every cycle of collective bargaining that we have. Right now we're in the midst of negotiating our master contract that covers all commercial office cleaners, over 25,000 members, the contract expires December 31st and the central employer demand in that bargaining as we speak is for our members to begin to pay a share of the premium because of rising health care costs. That if we don't resolve that issue we will not settle our contract on December 31st and that form of the health care crisis will manifest itself in labor

disruption in this city and I'm sure I don't have to speak for my public sector brothers and sisters but the issue of health care costs is central to their bargaining as well. There are many factors driving the health care inflation but from our perspective there are two interrelated factors that are central to that dynamic. One is the complete absence of any form of transparency in health care costs, you don't know either as a self-insured plan or particularly as an individual consumer walking into the hospital what any procedure is going to cost, that is a system that has been intentionally designed by the providers to ensure that there cannot be any form of comparability between the health care that has provided in systems. Not only that, many insurance company contracts with health care systems preclude the public dissemination of the actual cost data even for self-insured plans, that also precludes the kinds of transparency and examination which my brother has requested that this committee undertake so that the public can understand whether there are any clinical basis for the huge differentiation in costs between hospital systems for the… exactly the same procedure. We are fortunate in our funds that we are not constrained in being able

to disclose our… what we actually have to pay in claims for comparable procedures and some of you may remember that we ran a public campaign recently over the incredible price disparities between New York Presbyterian for example and other major hospitals in New York and those disparities showed for example that New York Presbyterian we were paying 25,000 dollars more for a hip replacement, nearly 7,000 dollars more for a vaginal birth, more than 5,000 dollars for a, a colon screening than, than the average claim that we paid for the rest of New York City hospitals. No clinical differentiation outcome, no medical basis for that kind of cost differentiation, no explanation of by why that variation in unit pricing for those procedures and that's not the full list of procedures that these kinds of disparities are, are present and prevalent in the system. So… where there's no transparency, where there are insurance contracts that preclude transparency and the ventilation of these kinds of differences you end up with these disparities which are simply a form of a tax on the entire system which come out of the pockets of our members when we go to bargaining in terms of what the wage outcomes which

come out of the tax payers money in trying to fund the public sector workers deserving need for quality health care and who benefits from this? That's the big mystery, who benefits from this? In a system which is supposed to be non-for-profit hospitals. So, we have… some of the insurance contracts also even preclude a fund like ours from doing what my brother has… is also doing is to try to fight, send signals to our members about how to avoid higher cost systems by having copay differentials and so even the ability to tier between quality hospitals so that our members are going to the hospitals which are not taking advantage of this lack of transparency and charging these higher rates for the same procedures even that ability to steer is sometimes precluded by these contracts which even self-insured funds have to manage to get around and that was also a concern for us when we were trying to access health care through, through Empire and others recently. So, there is a lot to be examined in those structures of those agreements and you know while there's much to be said about insurance companies role in this, if you're self-insured plan for us and the hospitals often try to divert what the question here is on this issue,

the issue is between our members, our workers and the hospitals, the insurance company is simply administering our plan, it's our money that we bargain from the employers that is being taken advantage of in this situation and that is putting the pressure on people being able to support themselves and still maintain their health care. We have also found and then I'll, I'll, I'll wrap up because on this topic it's hard to stop because it's so outrageous. We have also discovered that there's a, a significant difference in the percentage of out of network doctors between hospital systems. Northwell for example, which was also one of the hospitals that our data showed we… our claims payments for similar procedures were much higher than the average we paid in general across New York City hospitals, Northwell has a very… significantly higher percentage of out of network doctors than the other major systems. So, there's two problems with that, one is obviously the surprise bill, you don't know who your anesthesiologist is when you go there, you're not in a position to wake up and say oh please are you in my plan, can I substitute somebody, I'm going to have… I'm going to get balanced bill for

this because I didn't know you were out of network even though your hospital is in network, so that's one problem. And our fund we take care of our members, if they're in a situation like that which is an additional cost that we have to bear but also the out of network doctors tend or have… can often charge much higher than the norm for the procedure that they are doing and that's probably one of the reasons they may be out of network in order to be able to take advantage of that. So, this is an area in which you can't tell, there's no database that allows you to know, if I'm going to Northwell I am more likely than if I were to go to a different hospital to be subject to the potential of having out of network billing and there needs to be some transparency on this, some reporting on this and the hospitals need to take responsibility for ensuring that doctors who are going to be performing these services are in the network that is subject to the way the world as they consume health care assumes. So, we don't have people who are not in the ability to negotiate taken advantage of, forced to pay these bills and suffering the consequences which both committee Chairs pointed out results from this kind of situation. So, we fully

support the recommendations that have been suggested here and we are fortunate to have our health fund director Sara Rothstein who can go into some more detail and has some other recommendations. So, again we really appreciate the Committee's concern, we have to open the black box, pricing is a key part of what is creating the health care crisis and pricing relates to access, it relates to the health of New Yorkers and it relates to the ability of working class people in this city to continue to live a life with some sense of security. So, thank you for your interest.

CHAIRPERSON LEVINE: I think Chair Rivera wants to jump in with a question.

COUNCIL MEMBER RIVERA: I just want to ask and make… I, I could also wait until you all are, are done testifying but you know you answered so many of our questions in your testimony, it's… why, why do so many people receive care from out of network physicians even when they seek care at in network facilities and I think the answer is profit, there's no attention to the patient and I don't know if you have an, an answer on that but I just wanted to read one part of your testimony that I think is important

and I appreciate you just talking based on your experience and that's okay. You wrote that the health fund received a bill for reading the results of a heart test that was almost 60 times the in network county average of what the fund paid to other providers who rendered the same care in the same county and so are… so… [cross-talk]

LARRY ENGELSTEIN: When I… when I grew up that was called hutzpah.

COUNCIL MEMBER RIVERA: So, people are still… yeah, we have a Spanish word for that as well. Are people still… so, people are still receiving surprise medical bills and is there the arbitration process that patients go through because of these health care costs, what are the impact on some of your members?

SARA ROTHSTEIN: So, we think that the arbitration process is, you know a good step that New York State has taken to limit the sort of impact of surprise bills on members however like the rest of medicine we think that prevention is the best cure so rather than dealing with the surprise bills over the backend and figuring out whether you're paying 2,000 or 5,000 dollars for a piece of care that should have

only costed 80 or 100 dollars we think hospitals need to step up and take responsibility and prevent doctors who are out of network from providing care within their hospitals.

COUNCIL MEMBER RIVERA: Thank you and I know you're, you're going to add, add testimony to this so I just wanted to thank you for that because its astronomical, unbelievable and completely… I mean this is what… this is… this is oppression in, in many ways so just thank you for your testimony.

LARRY ENGELSTEIN: And you know it's no… it's, it's no coincidence that private equity is beginning to creep into the acquisition of these out of network doctor systems, so I'll leave that… I'll leave that for you to look at.

CHAIRPERSON LEVINE: Please Sara.

SARA ROTHSTEIN: Thank you. Good morning Committee Chairs Levine and Rivera and good morning Committee members. Thank you for your time this morning and attention to this issue. My name is Sara Rothstein and 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 insurance that

is fully paid for by employers who negotiate with the union and the fund is jointly governed by a board of trustees appointed by the union and the contributing employers. We provide benefits to 200,000 people across 11 states and the majority are in the New York City metro area. Our fund is self-insured and as brother Engelstein explained that means that we not the insurer pay all of the dollars for the care that our members use. We can design the benefits, but we can only take our plan design so far in combatting the sky-high prices that we're seeing at some of the hospitals here in New York City. We get our claims data which means that every time someone uses their benefits we know where they went for care, when, who provided the care and exactly how much we paid for that care. We pay over a billion dollars a year in hospital medical costs and we want to use our resources widely because our members pay no premiums, we pay no deductibles for in network care and they have a choice of providers and our goal is to keep the cost of out of pocket cost for when you need care low or zero so that our members don't have to decide between getting medical care and food or rent. As we've noted out of network costs are a significant

issue for us. Sometimes a member will see an out of network doctor on a planned basis when they choose to do so but more often what happens is members are treated involuntarily by out of network doctors when they are in the emergency room or have been admitted to the hospital for an emergent condition. Members go to in network hospitals thinking the doctors will take the same insurance as the hospital does which is not always true and when a doctor is out of network there's no pre-negotiated rate for the amount that we'll have to pay that doctor for the care that our plan participants needed. The 32 BJ health fund protects our members from these surprise bills because that's the goal of insurance to protect someone from catastrophic bills when they need emergent care and I'll say the problem of surprise bills isn't just a problem for us or for DC 37, it's a problem for other employers as well. So, the Northeast Business Group on Health represents purchasers in New York City including union health and welfare funds like ours, the city of New York itself and many corporate employers. The group recently conducted a survey of its participants and said that surprise billing was an issue, 40 percent

of employer respondents said surprise bills were a problem for them and for their employees. When we reviewed our data what we found was that not all hospitals have the same rate of doctors who generate out of network bills. When we reviewed our claims from 2016 through 2018 for care that was provided at a hospital we identified Northwell Health as the health system that had the most dollars from our fund going to out of network providers, the most claims in our fund from out of network providers and the bills from the highest number of doctors in our fund. The 32 BJ fund, health fund paid over four million dollars to out of network providers who provided care at Northwell's 18 hospitals in New York, most of which are in downstate New York, this is more than the total amount that the fund paid to out of network providers at any other health system in downstate New York and 13 percent of the dollars paid by the health fund to providers at Northwell Hospitals were for out of network bills meaning so if we took the entire pool we paid for doctor care at Northwell 13 percent of that was for out of network bills. I'd like to give you an example of an out of network bill that our members have received and you've heard about one

which was the 5,000-dollar bill for the cardiac… for reading the results of a cardiac test. I can give you another example, we have a member who was admitted to the hospital for having a heart attack and a doctor, an internal medicine doctor came by and on one day advised on a care of plan for the doctor… for the member and on the next day advised for a subsequent care of plan for the member. This is routine medical care within a hospital for someone to receive. The out of network doctor billed us 19,920 dollars for that care. When we looked at the comparable cost of care in the same county it was 805 dollars and when we looked across the comparable care at all other Northwell hospitals it was 759 dollars. So, these are two examples, we have many more examples where the out of network doctors want exorbitant rates for the care that they're providing. There are four Northwell hospitals in New York City and they include Lenox Hill, Long Island Jewish Forest Hills, Long Island Jewish Medical Center and Manhattan Eye, Ear and Throat. The fees charged by these out of network doctors are driving up the cost of health care for all New Yorkers and unlike our members many people have to pay all or part of the bills if their

insurance companies won't pay or if their health funds can't afford to pay. We think that these costs need to be kept under control and there have been a number of recommendations this morning that I support. In addition we would like to ask that the Council require that hospitals with physical locations in New York disclose the following; the insurance that the hospitals take and the… and total number of doctors at each hospital and the number of doctors who accept each of the insurance networks accepted by the hospital. We think it would be important to also note whether these are the same doctors who are generating the bills. I understand that Northwell Health commented in a story in Bloomberg News this morning that 99 percent of their doctors are in the network but those are not the doctors who are generating the bills necessarily and a disproportionate share of doctors are generating the out of network bills. Northwell Health also commented that they don't control the doctors but Northwell is the one who gives the doctors permission to provide care within the hospitals and we think the hospitals have a long way to go in stepping up their

responsibility for the financial conditions of their doctors who are operating under. Thank you.

CHAIRPERSON LEVINE: Thank you Sara.

LUCHIANA OWENS: Good morning Committee Chairman… Committee Chairs Levine and Rivera and good morning Committee members. Thank you for the opportunity to testify here today about the rising costs of health care. My name is Luchiana Owens, I'm a cleaner at a commercial office building and a proud member of 32 BJ. The health care we have in our contract makes a huge difference in my life, it covers my two sons and it does not require me to pay any premium payments to come out of my paycheck. If my sons or I get sick I am confident that we can go to the doctor and not risk any financial troubles. It is important however that health care cost do not rise too fast. Our insurance is funded by employer contributions that we win at our bargaining table. If the health care costs are out of control there is a less… there's less room for wage increase, pension payments, training and other benefits members rely on to support their families and improve their lives. I ask the Council to take action to help contain health care costs so working people can contribute to build

a good life for themselves and their families here in New York. Thank you.

CHAIRPERSON LEVINE: Thank you very much. Okay.

YENNY HERNANDEZ: Good morning Committee Chairs Levine and Rivera and good morning Committee members. Thank you for your time this morning and your attention to the impact of rising health care cost on working people. My name is Yenny Hernandez, I am a cleaner in a commercial office building in Midtown and proud member of 32 BJ and also a member of all commercial contract bargaining committee. I come to this country in 1996 from the Dominican Republic with hope of a better life however like many immigrants my path was not easy. After years of struggling to survive in New York… in New York including sleeping in the subway I had no choice but to send my son back to the Dominican Republic. I found a minimum wage job, but this wasn't enough for me to bring my son back here. For five years I lived in New York without him, missing his first step and all the other important moments in the first years of life. My life changed when I got a job as a cleaner that paid a good wage and provided benefits. I had

the security I needed to bring my son to the USA. A few years ago, when my son was 15 years, he needed two emergency surgeries in 48 hours, the costs were completely covered by my insurance. I can't tell you how amazing this was, I would have been devastated if, if my son needed care that I could not afford. My union fight to ensure we would have quality health care in all contracts, right now are… we are negotiating the contract that covered 2,000… 220,000 commercial cleaners. We will stand together, we will fight and have no doubt, we will win but raising health care costs made the fight harder than what i… I ask that the Council does what it can to contain health care cost so working people can continue to build good lives for themselves and their family here in New York City. Thank you.

CHAIRPERSON LEVINE: Thank you Yenny and thank you to this excellent panel. Henry could you clarify the role of private equity that I think unbeknownst to most New Yorkers is now buying up these provider networks and though we have a law against for profit hospitals in New York State, they're in there, who are these players and how is that in any way distorting this sector?

HENRY GARRIDO: Well as you know we are… I am a trustee on the pension system, so I'm limited to what individual information would have been as a trustee because I have… I do share a responsibility to protect some of the data but I can tell you without naming names that… and what we have found is that at least private equities look at what is most profitable, plain and simple and it's not just private equities, we're seeing hedge funds who have gotten into the business of health care in order to literally gamble with people's lives to make a profit. You may have seen in the news the hedge fund that increased the drugs for HIV over 700 percent, we have seen this as a trend, this is… health care is a big business in New York and elsewhere and they have seen it as an opportunity to invest which, which if, if you don't mind brings an interesting point the question is look if health care is a national crisis why are we here today, right, why isn't this being dealt in Washington D.C. and everything else and I want to take a point about this because I think this is a critical point of why we're coming to you today. Occasionally you may see me cough, I have a, a condition where I have sinus conditions, about two

years ago I went to one of these local hospitals and I had surgery, I had a deviated septum and a broken nose and when I came out of the hospital I got a surprise billing and I said oh let me find out what it is, right, where is this bill coming from and I fought the hospital and demanded to get a detailed billing and what I found was very surprising and it's a very personal experience. They tracked me 26 dollars for a band-aid now this magical band-aid I thought will… probably going to cure all of my conditions as you can see it hasn't and, and the reason why I'm saying this is this, you, you don't need Medicare for all to, to really realize that a 26 dollar band-aid is not acceptable, that it is not… that a band-aid I can buy down in… should not cost that kind of person fortunate I was able to pay, to take care of it for myself and I cannot think of how many people who are living paycheck to paycheck who won't be able to do that and this City Council has taken the leadership role on many of the progressive issues before they became popular, before the FIFA 15 City Council is fighting for a living wage, before national discussion about paid family leave it was the City Council, this City Council that was asking

for how can we not have paid family leave in the city and the state of New York, before any of these provisions of housing and… that were popular among providers and, and developers who are getting subsidies it was the City Council who are raising questions about the investment of the city into major developments and the affordability of those apartments and so I'm asking the same thing today that yes, we should look at hedge funds, we should look at private equities and we should look at what is behind but we should also ask the very hospitals that are right here in New York who are taking care of and advantage of in our opinion of tax breaks and businesses to ask the question why do you charge 26 dollars for a band-aid, the answer is because they can and the answer is because they won't be stopped, right, I'm sure there have been many band-aids provided by the same hospital and as long as they can keep getting away with it they can and so for us the important question has to be is… we should look at the mechanism behind it but we, we should also look at those hospitals who are passing along the same charges to the city of New York as an employer, to the private commercial buildings as an employer. So,

all little shops are now, now required by the ACA to provide health care and I think that's an important point about the role the City Council can play in pushing back and asking questions and laying the groundwork here in New York City as the leading city in, in the country to begin to ask these questions.

CHAIRPERSON LEVINE: You're perhaps limited in what you can reveal based on your role as a member of the pension board but I do believe that it's been reported that some of the hedge funds which are not only profiting off of these obscenely priced out of patient provider networks but lobbying against transparency reform happen to also have business in the pension fund, I realize you probably can't go into that but that's one hell of a contradiction that…

HENRY GARRIDO: Well I can say this, it was one of the reasons why the New York City retirement system looked at divesting from hedge funds and I led that fight, I'm very proud of it. While the returns are very poor, right, they get… they were really gambling with people's lives so the New York City retirement system divested from hedge funds as a result of a lot of the analysis and we

just think it's outrageous that they're taking our own money to create a system that, that exploiting people and people's health condition because people will question anything except for their health. If you're in an emergency room and you need to stay alive you're not going to cut corners, you're not going to say listen close me back up I'm going to go to another hospital that's going to charge me less, it's not going to happen, right, so when you're in an emergency and operating table you're going to try to get what is best for you, for your family and everything else that's why it makes it so outrageous because they're really holding us hostage and holding working people hostage to a system they created that they rigged with our own money and I think it's time we need to demand answers for the system that has been created.

CHAIRPERSON LEVINE: Can, can you or, or perhaps it would be a question for 32 BJ, can you clarify when a patient is stuffed with one of these exorbitant bills because of out of network providers who ultimately has to pay that and who's negotiating those prices, is anyone negotiating those prices?

SARA ROTHSTEIN: Yes, I have someone on staff who negotiates each and every one of those bills when they come to us.

CHAIRPERSON LEVINE: Is… but no, no kind of uniform negotiation across… [cross-talk]

SARA ROTHSTEIN: Its uniform in the sense that we're committed to not having our members pay those bills so the bills will come to us directly or they'll go to the member and the member will send the bill to us, we have someone who'll reach out to the doctor to negotiate those bills and I can tell you on the 5,000 dollar bill for reading a heart test we didn't pay the 5,000 but we didn't pay the 80 dollars either and so that winds up costing the fund money and that's part of why we need increased contributions to the health fund just to maintain our benefits every year which leaves less money on the table for wages and other benefit improvements.

CHAIRPERSON LEVINE: Could, could you estimate how much is… it's essentially coming out of your, your member's pockets, right because ultimately every dollar that you have to… [cross-talk]

SARA ROTHSTEIN: That's right… [cross-talk]

CHAIRPERSON LEVINE: …negotiate for the health care fund is a dollar that you're burning political capital you could have used on wages.

SARA ROTHSTEIN: That's right.

CHAIRPERSON LEVINE: Can you estimate how much a year these kinds of exorbitate bills, surprise billing, the out of network cost, what the impact on just your one union is?

SARA ROTHSTEIN: Sure, so at Northwell alone we paid over four million dollars over a period of three years for out of network bills, at other downstate hospitals the figure is probably closer to ten to 13 million dollars.

LARRY ENGELSTEIN: But since we've implemented a tiered hospital network based on the claims data that we had by having a co-pay differential, we are saving tens of millions of dollars by avoiding the higher priced hospitals but to answer your first question, 32 BJ members are fortunate to have a health fund with the size and capacity to negotiate this situation both to take the heat on the bill but also to have the institutional power to negotiate what the outcome is, that's our fund and we're proud of it but there are thousands of

other people who may not have that ability when the situation arises for them and it's good that there's an arbitration system but that is a process which also requires sophistication and… which is complicated and places a burden on the average user to figure that out, it's hard enough to figure out what to do when you get the bill, not everybody can do what, what my brother did here in figuring out that he paid 26 dollars for a band-aid, you know so that's the structure of the system, it's a step forward but it still doesn't deal with the underlying question which is the hospitals have to take responsibility for the people who are performing services on their premises.

HENRY GARRIDO: Can, can I just add because for the city of New York it's a… it's different, right. I appreciate what the brother, brothers and BJ are doing, for us it's actually coming out in two ways. One, rate increases because we have a bifurcated primary care hospitalization between primarily GHI and Empire, right, so that extra rate goes up and it gets passed onto the city as the employer but also when the claims are done there's an excess billing that goes in there where

the city as the employer, the unions through the stabilization fund have to pay a major part of it. Last year alone that amount was over 315 million dollars, right and it… we're looking at the trend that everything we've done to try to curb primary care, prevention has resulted in a lower increase of people and even though people are going less to the emergency room they have ever been because of the changes we made since 2014, the rates are going up so how because the hospitals are changing the rules, they're changing, charging for a patient, increasing the, the Medicaid rate multiplying it by 400 percent in some cases so the amount of stuff that we're looking at is just business practices that have nothing to do with quality of care or nothing to do with rising costs of health care. These are just for-profit decisions and what the city pays as an employer which you know as I said it continues to increase, the rate of hospitalization is increasing by larger than any part of the city budget period. Now let that sink in, no part of the city budget has increased for the last three years as high as the rising cost of the hospital bills not even prescription drugs and that tells you something.

Within that group of 169 hospitals there are five hospital systems that are responsible for almost 80 percent of all those bills and all those increases. So, it is time for us to start questioning what is the rationalities, did… yes, health care cost is expensive and New York is an expensive town, we're not denying that but why should some of these things that are popping up between even the, the networks, between their own systems have 20 and 30 dollar discrepancies for hospitals within the same network, it makes no sense to us and we, we are demanding answers.

CHAIRPERSON LEVINE: And just like every dollar that private union like BJ puts to health care is a dollar out of the wages of their members we're putting out I think, you know maybe four billion a year into health care as a city, is that right and every one of those dollars… is it more, what's it up to now?

HENRY GARRIDO: 9.3…

CHAIRPERSON LEVINE: Okay, nine, nine, nine?

HENRY GARRIDO: About nine billion dollars.

CHAIRPERSON LEVINE: And, and every dollar that goes to that could have gone to either wages or increasing head count or services, it's, it's a huge opportunity cost. I do want to pause and pass it off to my Co-Chair Rivera.

COUNCIL MEMBER RIVERA: I just wanted to add that, you know when we talk about the, the FPIC board and… at the state level and the decisions that they're making, the head of that board is the head of Northwell so, you know when we're… transparency and accountability and how we have the discussions on decisions that are being made for services, you know you, you wonder like who has a seat at the table and how we can make sure that we have that voice for the average person who's getting a surprise bill so we'll have questions for the hospital systems to ask what they're doing to improve the patient experience in terms of what they can expect and what they deserve so I just want to, to thank you all for, for your testimony. And can… I want to just turn it over to some of my colleagues, he's not here anymore… Reynoso.

COUNCIL MEMBER REYNOSO: Alright, thank you so much. Thank you both… thank you all for being here.

[speaking Spanish]

COUNCIL MEMBER REYNOSO: So, it's a so nice to… so nice to have you here. I wanted to ask… I wanted to just make a statement or a testimony here. When I worked in the City Council as a… as a Chief of Staff I had a hernia, I decided to postpone the surgery. When I had some pain I went to my primary care physician and he told me where it would be the best place for me to go that took my insurance should anything happen emergency wise, I didn't want to get anything done because, you know we, we do important work here in the City Council and I couldn't imagine taking days off. So, it eventually got to a crisis mode and I was in so much pain one day that I had to go to the emergency room, I go to the emergency room and they say I'm in, in… [cross-talk]

SARA ROTHSTEIN: Network…

COUNCIL MEMBER REYNOSO: …network, thank you, I'm in network and I feel great about it, I'm going to get the surgery something I shouldn't have postponed for so long. It happens, about 30 days

later I get a bill, anesthesiologist is not in district… in, in network which I didn't even know what that meant and this was a year before the state law was passed where there were surprise bills. I was making 55,000 dollars a year and lived in Williamsburg Brooklyn, I couldn't afford to pay that immediately, I ended up having to go into collections and it actually helped me because in collections I was able to negotiate a better price of what I got… I have to pay, my credit took a hit for a long time but I was able to cut the cost by about 50 percent and had to pay it in one shot so I had to pay even the 50 percent cost in one shot and it was just a… amazing to me, it's just mind boggling how we even let that, that happen and I started blaming myself saying why wasn't I paying attention but I did, I specifically asked if it was in, in network and, and I thought everything in that hospital was in network and I thought I was safe, being responsible. So, just knowing that ten years later we're having the exact same problems, the exact same issues even as we've moved into the state of emergency as a country into having to deal with the health care and how, how we… and insurance and we still can't seem to move the

dial so I'm, I'm glad that Henry you gave us these very clear four steps that we can take in the City Council that can help address on some of these issues. Again I really do think that the state and the federal government unfortunately have more to say on this than we do but if we can do something locally that can start setting a trend or start moving the conversation I absolutely want to be a part of it. That thing set me… that bill set me back a long time, the anxiety I had, it was the only bill I couldn't pay in my time, the anxiety I had about the calls, constantly calling me, it was like 3,000 bucks and I couldn't afford it in one shot for this anesthesiologist that was out of network so I'm grateful that we're having this conversation now that my experience is hopefully a thing of the past because of state law but also because we're having this hearing so thank you so much for being here and again I just feel like I'm a well-informed constituent and still got caught in, in, in the… in the loop and I just… I'm happy that we're bringing attention to these issues so thank you so much for being here.

CHAIRPERSON LEVINE: Thank you… [cross-talk]

HENRY GARRIDO: Thank you Chairs… [cross-talk]

CHAIRPERSON LEVINE: …Council Member and as you say if someone of the caliber of a Henry Garrido and Antonio Reynoso is struggling with this then my goodness the average New Yorker is really, really facing an uphill battle. We have a question from Doctor Eugene.

COUNCIL MEMBER EUGENE: Thank you very much Mr. Chair, let me first and foremost take the opportunity to thank my colleagues and the two Chairs, Chair Levine and Chair Rivera for your leadership, thank you so very much, to my sister…

[speaking Spanish]

COUNCIL MEMBER EUGENE: Okay, it's in Brazil. Let, let me say that… I want to take the opportunity also to thank the leaders of 32 BJ and district 37 and all the advocates for what you're doing, there's a big crisis, I believe the biggest crisis in the United States is access to affordable quality of care and in your testimony my friend and our leader Henry you say that you are begging us,

you're not begging us we have to thank you to commend you for what you're doing, you're doing the right thing to stand for the hard working people who make New York City great, the hard working people who work hard to make our system into the wonderful system that it is and also… I think also Mr. Larry you mentioned that the health care is a priority for 32 BJ, you're right, it should not be only a priority for 32 BJ and I keep saying all the time to my colleagues and every year health care should be on the top of the priorities of government, it should be because sick… you know all human beings who are facing many challenges in life, affordable housing, education, jobs but sickness is a big challenge also for human beings and it is a condition of human being. Human beings get sick and I believe this is the responsibility of the government to provide access to quality health care to human beings, this is a human right issue and I got another public hearing at the same time, I got to run but I got one question. Think about it, somebody like Henry who's educated, who's in the position to understand the system, he was surprised by surprising bill and my colleague Antonio Reynoso also was in the same

situation, just imagine the same… the simple citizens, the people who are not educated like you about the system, who don't have the knowledge that you have of the system. I saw many of the hardworking people, they are afraid to go to those to die for the same reason, they're afraid to go, they are sick, they need medical attention, they cannot go, they're afraid of the bill, you know what happens they wait and they wait and they wait because they cannot afford it and when the situations become worse it's a sad situation for them, for their family members and also for the city because we are going to end up paying more. Now there's one question I want to ask about this, this part of the… your testimony, Miss Sara mentioned that the 32 BJs have fund to protect members from surprise bills from out of network doctors but the high cost of these bills threaten the stability of the fund, this is a serious issue and I know that has a very strong impact in your… in the pension fund and also in the ability to give other services to the members. We know that we have… we City Council members, we got to do everything that we can do to fill the gap to ensure there is transparency, to ensure that you know we fill the,

the, the gap of, of costs between hospital but I see in this situation there's an urgency also because your funds are being effected, impacted by that, what do you believe… by the time that we are waiting to bring legislation, legislation to, to resolve this issue, is there any other thing that we as a City Council we can do to help you, you know carry the debating of this situation?

HENRY GARRIDO: Councilman thank you for the question, I think it's a very important one. We simply cannot afford to wait for national legislation or even state legislation for this. About three weeks ago the plan which we have supplemental prescription drugs approved a member who requested and was entitled to a drug that cost 1.8 million dollars per person and I thought that was just outrageous, right, it was a pretty rare disease but it was just outrageous but she was entitled to it so we covered it and I figure we have hit the mark, two weeks later a new drug comes in, 2.2 million dollars, we have ten drugs that have been approved for over half a billion dollars… million dollars each for people so the plans will run out of money and the question is what happens to those individuals that the unions like BJ

and us are providing, you cannot… you know all of our collective bargaining had been tied into this and yes, some of it is surprise billing and people they go to collection and they get infected now they can't apply for housing, they can't apply for a home, they can't apply for any of the services because the credit… the credit takes a hit, some other people have had their checks garnished here by collection agencies, all kinds… it affects their life entirely but if the system is not changed or looked into now starting with those four recommendations that we made here's what we project is going to happen. The funds are going to run out of money, those people who are part of the city workforce for instance that I represent which represent 1.4 million New Yorkers will be the responsibility of the city to take off because you have a promise to them and the state in terms of their pensions so they're going to be retirees anyway, they're going to be active members of it and I'm not just talking about my DC 37 members, I'm talking about the City Council members, the staff, I'm talking about the, the managerial employees who are not representative of our union because we're all in the same system… [cross-talk]

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

HENRY GARRIDO: …so we owe it to ourselves to look at how much we're spending and look at the hospitals in particular and say to them, what are you doing to help this crisis, are you just tacking along unnecessary fees and charging the 26 dollar band-aids and imagine if they're charging that for a band-aid what they're charging for a colonoscopy or a hip replacement, we have the numbers. Unfortunately we can't share individual numbers but our experiences is no different than, than, than 32 BJ's experiences; 30, 40, 50,000 dollars above trend within the same network with no possible explanation other than the fact that we charge you because you can and when you challenge them and say hey, what about this 40, 30,000 dollars they'll say well just put us out of network because they know the members will hate it, right, that they don't have access to these… this care organization and hospitals and that's holding us hostage when I said that so I think it's a very important point that we cannot wait Council Member, I think you made a very great point that we need actions now and if we

could start by the simple premise that Larry mentioned transparency is important, show what you're charging, show what you're charging people up front, tell them which hospitals are covered and what not, tell them how many doctors are covered or not so that you don't get surprised 30 days, 40 days later with a huge bill or the funds don't have to go in the fence something that at that point has already passed, right, in service. We are really struggling in this and you said it, maybe beg is a strong word but I'm not afraid to beg for the members that I represent… [cross-talk]

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

HENRY GARRIDO: …when the issue of justice is at stake and that's what it is today so thank you.

LARRY ENGELSTEIN: I just… I would just add… [cross-talk]

COUNCIL MEMBER EUGENE: Thank, thank you.

LARRY ENGELSTEIN: …because Council Member Reynoso talked about the complexity of who has jurisdiction over this issue between the different levels of government but the city and its proprietary

capacity as a major purchaser from these hospital networks it would seem to me in that capacity alone leaving aside a regulatory one should have the ability to demand equivalent prices and disclosure before it goes to market so that's one piece of it and all of us in the consuming community if you think about us in that way for this purpose, a city we believe has jurisdiction to look into from a consumer perspective transparency and pricing and disclosure and also inquire in to provisions in the insurance contracts with the providers that preclude transparency or the opportunity to steer if the prices are different and the like so we do think there is a space both wearing your proprietary hat as a purchaser and a regulatory hat from the consumer advocacy perspective for you to navigate between the state and federal places and I only want to echo again that the centrality of this issue and the lives of our members and for the stability and the collective bargaining system both in the private sector and the public sector in the years ahead. Thank you.

COUNCIL MEMBER EUGENE: Again, thank you my colleagues, thank you very much for your

leadership and to all the advocates, thank you for what you're doing, thank you.

CHAIRPERSON LEVINE: Thank you Doctor Eugene and Council Member Powers.

COUNCIL MEMBER POWERS: Thank you, thank you for the testimony and thank you to both Chairs. I think… I think everybody agrees that if you get the surprise event during… into a hospital in an emergency believing you're in network and exit with a bill and find out that you received out of network care that its, it's beyond reasonable consumer protections, potentially fraud and it is harmful to that individual without their ability to contend to those… to some of those charges and even, even accepting that hospitals are businesses and there's competition and they're allowed… in some cases allowed to compete really… related to service care and even pricing. When you go to an emergency room that's… you don't get to… you don't get to shop the market you have to… you have to go to the… either the nearest or the best service to you at that point and I… and I noted that I think it was Sara, Miss Rothstein had mentioned doctors are mostly in network, that was in the Bloomberg article today

which I think is actually… sorry, which I think is actually true but for the employees but not for the admitting doctors that are often brought in and then are a part of the out of network cost so I think there's a… I think that, that sort of seems to be the crux of the problem is when they bring in admitting doctors that are independent and not employees, but I will stand corrected if I'm wrong about that.

SARA ROTHSTEIN: No, that's correct.

COUNCIL MEMBER POWERS: Oh and I know there was a 2015 law, I think it was amended again this year which discerns to some of this and I… so I wanted to understand the problem beyond what… where the fix is made by the state law which I think did for emergency treatment some changes to the out of network versus in network cost, can you explain… [cross-talk]

SARA ROTHSTEIN: Sure… [cross-talk]

COUNCIL MEMBER POWERS: …what those changes did and then how the problem exists beyond that?

SARA ROTHSTEIN: Sure and if I may I just want to take a moment and say I actually don't think that hospitals in the city today are competing on

price or on quality, I think the lack of transparency into hospital prices has prevented any competition on price and there's actually a real allergy to sharing real meaningful quality data as well so the Leapfrog group collects and publishes quality statistics for hospitals across the country, there are a number of health systems in New York that have refused to share their quality data with the Leapfrog group and refused to share significant other quality data and when we issued an RFI to hospitals on maternity care some hospitals opted not to participate because they didn't want to share quality data with us so I just don't necessarily agree that the hospitals have been forced to compete on quality or on transparency, I think they're competing on who can take over the most ads in the New York Times today. But that aside your question was about the surprise bill law in New York State which was first passed in 2015 to address out of network bills from hospitals and was amended this year to address out of network bills from out of network hospitals, the first was doctors the second was hospitals. We think it's an appropriate backstop to when someone does receive an out of network bill, it means that if in fully insured plans like

marketplace plans or small employer plans if someone gets an out of network bill the insurer and the doctor or the insurer and the hospital have to duke it out or go to arbitration or in our case we and the doctor or we and the hospital can duke it out or go to arbitration. We think it's good to have that mechanism but we think that prevention is the best way to address surprise bills, they don't have to exist, hospitals could say to their doctors either you have to be in network and take all the same insurance products that we take or they could say, you know for some reason and I can't think of a good one but if there is a good reason that you can't be in the insurance network you at least aren't going to charge more than the accepted in network rate. Our concern isn't that the doctor is necessarily out of network, our concern is the prices that they're charging and so if hospitals could get their credentialed physicians to stop billing at egregious rates no one would need to go through that complicated state process which is good that it exists but it would be better to prevent the out of network billing in the first place.

COUNCIL MEMBER POWERS: Got it and, and to the, the point about… I was saying about shopping around for care, I mean if you talk about maternity for an example, I do think people… that's a very important decision for people's lives, I think they do actually try to be… collect as much information about it but I think there are many issues where you don't have the luxury of being able to look around or talk to others about service and care. The… but in the 2015 law am I… am I correct… I, I, I… as I understand it there was some sort of changing in terms of how, how, how out of network care was paid for with emergency treatment, am I correct saying that meaning I thought that they actually did do some transfer over where you had to now charge in network, is that… am I incorrect… [cross-talk]

SARA ROTHSTEIN: There's no requirement for out of network doctors to accept the in-network rate.

COUNCIL MEMBER POWERS: Okay and, and are… is, is 32 BJ covered by that law?

SARA ROTHSTEIN: We have been working with the state to figure out how we can work with that law, we could opt into that law, we find it to

be generally easiest just to reach out to the doctors and negotiate directly and that's generally the first step before you go to arbitration in any event and we're generally successful in negotiating bills and haven't had to go through the state process but yes, we could take advantage of it.

COUNCIL MEMBER POWERS: Got it, thank you and the… is, is there any attempt to do some like matching like potentially if there is an in network provider and to try to match an individual with a… with an in network… [cross-talk]

SARA ROTHSTEIN: Yes, and for… [cross-talk]

COUNCIL MEMBER POWERS: …doctor or… [cross-talk]

SARA ROTHSTEIN: …planned care we always tell our members to go to in network providers and for planned care people can do that but in the instances we shared with you today people had emergency circumstances which led them to go to the hospital and then… were then treated by out of network doctors or… [cross-talk]

COUNCIL MEMBER POWERS: But is there even an attempt to try to… is that… I mean would there be

an available in network doctor that they could… [cross-talk]

SARA ROTHSTEIN: So, in some cases hospitals including Northwell have opted to staff some of their inpatient units with out of network doctors and so in some instances there is no in network doctor available to provide the care.

HENRY GARRIDO: And, and then a good case was made about the issue of anesthesiologists, right, you go in, you know you're in emergency, right, you, you're not… you're not going to say well don't give me anesthesia, do the operation, get me an in network hospital, you're in pain, right… [cross-talk]

COUNCIL MEMBER POWERS: Yeah, yeah… [cross-talk]

HENRY GARRIDO: …so some of the stuff that's there is, is part of the system, they're, they're basically rigging the system against the law, they're trying the system that, you know 2015 we were pushing for this law, 2018 we, we, we lobbied the state because it is a good law but it does provide… it's not as comprehensive as they should be, fortunate it was what we were able to get with major fight back from the industry, right, who was out

there lobbying strenuously against it and we were saying simply look, if you're that sure about the in network and you've done everything possible you shouldn't be afraid to be able to go to dispute resolution, right, you shouldn't be afraid to share what you did or have not done in terms of charging individuals. The problem is as I said before when people are in pain, when they need emergency services, when their kid is sick in the middle of the night, when you bring somebody to the emergency room because your mother is dying or your grandmother has… just had a heart attack, you are not going to go in there and say are you out of network, are you out of network, is he out of network, that, that doesn't happen, you, you, you trust that your insurance that you pay for, that's what you have it for, is going to cover you, once you know that a hospital is in network you trust that they're going to do the right thing and these hospitals are taking that trust and turning it on their head and, and they're literally holding people hostage to this and this is outrageous and it needs to stop and we need you, we need your help in pushing back and asking questions why is this happening, why are you doing the kind of things that

you're doing both from the perspective of the consumer but also as an employer for the city of New York who spends billions out of the budget you all negotiate, billions without any necessarily check back and we, we need to do something about this now.

COUNCIL MEMBER POWERS: Yeah… no, I, I, I absolutely agree with you and I, I think the hospitals actually right in this moment should be at least trying to find people that are providers in it. I'll, I'll… and there… I just wanted to ask one last question which is… and by the way I just… generally seems like there should be some benchmarking here, even arbitration seems like it's like… and… you know uncertain and costly and should actually be some fix to this that does not require you to go into arbitration over time but there's a federal… [cross-talk]

LARRY ENGELSTEIN: Benchmarking requires transparency.

COUNCIL MEMBER POWERS: There you go.

LARRY ENGELSTEIN: Because how do you have a benchmark when no one says what their prices are?

COUNCIL MEMBER POWERS: Yeah… no, I understand. The New York federal legislation on this topic right now, I know the senate and the house have been discussing it, any updates on that and how does it impact your networks or your employees?

LARRY ENGELSTEIN: In, in between the impeachment sessions?

COUNCIL MEMBER POWERS: In between the impeachment sessions…

HENRY GARRIDO: If you're referring to H3… HR3 which is a house bill?

COUNCIL MEMBER POWERS: Yeah.

HENRY GARRIDO: Which is in there expected to be passed before the end of the year, the house will be calling for a vote in a week, that's what we're being told but there's no expectation the senate's going to actually take in an action so it's got a lot of good language, we're supporting it, we're pushing, we expect the house will pass it before the end of the year but if it doesn't move in the senate… like I said, you know health care is complicated, we don't expect with the current leadership in the national scene that this will happen but you know if you read the recent

publication it is a great bill and we're supporting it wholeheartedly.

SARA ROTHSTEIN: Agreed.

COUNCIL MEMBER POWERS: Okay, thank you, thank you to the Chairs for questions.

CHAIRPERSON LEVINE: Thank you Council Member Powers and now Council Member Holden.

COUNCIL MEMBER HOLDEN: I'll try to be quick but thank you for your testimony. Henry I want to echo, having had some experience with hospitals in the last few years one as a patient and one on behalf of my mom who was actually I felt like she was prey in the hospital and this, this was recent and we're in a little room and I'm standing with her and there was armies of doctors that kept coming in and out asking the same questions, hours apart, I was in there for 48 hours with her in a very small room in the emergency room waiting to get a bed and every few hours a doctor would come in, I'd answer the same questions on behalf of my mom and then… and then another doctor come in two hours later, same thing, same questions, I said is anybody writing this down, why are… why are you guys… there's computers nowadays, we can actually input this and the doctor

coming in two hours later could read it, no, they weren't doing that. This went on for 48 hours, I felt they were padding the bills, I felt they all… everybody had an interest to pad the bill, everybody… the hospital has… certainly has the interest and I may be wrong on this but I just felt this is a conspiracy, that this was intentional, this is driving up the cost, this is ridiculous to answer the same questions before… if you do that you lose patients very fast and I'm talking about you… I just started to lose it, I said there's something going on and there needs to be an investigation here, this hospital and I was in the hospital… that same hospital three years earlier and it had only gotten worse with my mom three years later but I was annoyed the… three years ago when I was a patient because they kept doing it, they wake you up and ask you the questions, you're sleeping soundly, they give you pills to go to sleep because I broke my… I broke a couple of ribs and the… and I wasn't really in pain that much but they kept throwing, you know drugs at you but they wake you up every three hours to ask you the same questions from a different doctor coming in and I just said somethings going on here and now it's

worse in 2019, much worse and so I don't know if you're negotiating with, with these hospitals and you see the duplication but this is totally out of control and it's driving up the cost but do you… do you try to negotiate a little bit on that, I mean I guess you do but do you see the duplication many times from doctors on different reports?

SARA ROTHSTEIN: So, I don't want to comment on the specifics of care being provided in a specific hospital instance but I can say we are looking at our claims to try and evaluate and quantify low or no value care and where that's being delivered and how much it's being cost… how much it's costing us.

LARRY ENGELSTEIN: Otherwise known as walk byes.

COUNCIL MEMBER HOLDEN: Walk byes, that's what it's called?

[off mic dialogue]

COUNCIL MEMBER HOLDEN: That's what it… that's exactly what it was and, and you didn't know who was… it was like almost a comedy act you didn't know who was going to come through that door at any time and just pop in not even… many times they're

asking the question not even writing it down, they just want to… they just want to bill you for it. Thanks, so much Chair, thank you.

CHAIRPERSON LEVINE: Thank you I, I just have one, one final question, can someone explain why this is not the insurance company's problem, are they… I mean they… why aren't they just contracting with all of these out, out of network doctors?

[off mic dialogue]

SARA ROTHSTEIN: Sure, so I think the issue is a price issue so when you have a doctor who wants 5,000 dollars compared to the 80 dollars in network we could tell our insurance company to go out and contract with that out of network doctor but the price for bringing that doctor into the network would be 5,000 dollars instead of the 80 dollars and so that would only boost our prices and so our concern is really the prices the doctors want more than whether they're in network or out of the network, big networks are always good but not at the cost of increasing our cost for providing affordable benefits for our members.

CHAIRPERSON LEVINE: Got it…

HENRY GARRIDO: In, in our experience there's also like I said the hospitals hold a… I'm, I'm not making excuses for the insurance company but what quite happen… quite often will happen is when negotiations are taking place they'll say okay, so don't put us in your network, you won't have NYU or Columbia, go tell your members that they won't be able to have access to those hospitals, good luck, right, and out of network and I'd like to be able to say that Spanish word you were mentioning before a few times with a very thick Dominican accent sometimes but you know what, you have to think about the people you're negotiating for, right, if you're in Westchester are you going to go down all the way, you know 15, 20 miles for an emergency room, Westchester Medical is the… one of the highest hospitals, I'm naming names, hospitals in there, right, so you want to be also conscious of the fact that people need quality care within their neighborhoods, within the proximity of where they live and their family members and we see there's an effect on it so what they basically take in the position in negotiation is pay us what we ask you or we walk and that's, that's not a position that we

want to. So, in this case what I'm asking the City Council to say, listen, we're giving you hundreds of millions of dollars in tax breaks, we're giving you a contract for 1.4 million people, we're giving you all kinds of easements in the city, what are you really providing for us as an employer, what are you providing to the citizens as consumers, what are you doing to improve health care and avoid redundancies and avoid the walk byes and all the things that you're doing other than making a profit or are you basically just, you know padding the bills in a way that its effecting all of us, those are the questions we would like for you guys to ask those hospital networks.

CHAIRPERSON LEVINE: Thank you so much to this entire panel and… [cross-talk]

COUNCIL MEMBER COHEN: Chair, Chair, I'm sorry, I know I, I missed my opportunity, but I snuck back just at the… do you… would you mind?

CHAIRPERSON LEVINE: Not… you have impeccable timing.

COUNCIL MEMBER COHEN: I appreciate it, thank you very much and I… and I apologize that I had to, to sneak out for a meeting but I, I just wanted

to make sure that I was clear on, on what the issues were and I, I, I was actually surprised to hear the, the, the out of network issue how substantial that is and I guess everybody knows somebody who that's happened to but somehow you think it's an anecdote that it's not systemic and I, I was surprised how much of your testimony was related to that and how serious the scope is of that problem and that… and it seems like a solvable problem today within EMR, everybody knows what the patient's… who's… what they're coverage, coverage is why would you… you know it says right there this patient has this plan and we have a provider who… do you know… I mean I guess we, we don't know the answers to how such a solvable problem… maybe that is a, a… also a legislative solution, I mean it's just a question of just looking at the record and saying that we, we provide… we have the services that this patient needs and they're covered. So, I, I, I found that… you know what also I, I represent a number of hospitals in, in the Northwest Bronx and I, I'm not actually convinced although they have never opened their books to me and I… and I am aware that their previous executive did make a, a very… a very substantial salary but I'm not

that convinced that the overall health of that… financial health of that institution is that great, do you think… you know… you know Montefiore where I represent does provide a tremendous amount of services to uninsured and underinsured people in the Bronx and I think that that contributes, you know to… you know the… there's a contributing factor in their… in their financial health and you've identified some providers who you think are particularly, I don't want to say egregious but maybe egregious… [cross-talk]

LARRY ENGELSTEIN: Egregious… [cross-talk]

COUNCIL MEMBER COHEN: …is the right word, yes… [cross-talk]

LARRY ENGELSTEIN: …I would say egregious.

COUNCIL MEMBER COHEN: Yes, but did… I guess to Sara when you're negotiating do you have any leverage with… like can you… we don't want to provide services if, if Northwell is a bad actor do you… what is the leverage you have to… over, over those negotiations?

LARRY ENGELSTEIN: Well from the union's perspective we are… we want to make to make sure our members have access to a, a, a broad range of hospitals and other providers both as Henry pointed out because they live all over the place and we want them also to have choice where its possible. If we have the ability to tier and steer based on pricing we can do that through education and co-pay differentials that will still allow people who are determined to go to a higher priced hospital to pay some of that cost but also over time if enough of us do this then it will have an impact and will ultimately force the higher priced hospitals to change their pricing, if 1.4 million New Yorkers and our 150,000 which are in the private side were all to go forward together and say to the higher priced hospitals at least based on what we've experienced with our claims data, you're going to lose business here on a scale that's significant to you, we assume, there should be some market rationality at that point. The thing about New York City that is different than other major markets is there… most of the larger private sector individual employers are, are universities who are… often are tied to hospital

institutions but you don't have a Boeing, you don't have a, a large private sector employer that is in the business of being self-insured and going to market head to head with the major hospital change, you have the city, we are an aggregator of a lot of small employers who through our fund become a collective purchaser and that's true of some of the other Taft Hartley funds so ultimately we have to have a market dynamic or a regulatory dynamic that changes the pricing differentials and with… until you have that construct your choice is and you don't always have this choice because you're seeking access to the market if you're of our size through an insurance company, the insurance company defines the network that you're getting access to the platform, you can't go to the insurance company necessarily and correct me if I'm wrong Sara and say cut this hospital out…

COUNCIL MEMBER COHEN: But… 32 BJ is self-insured essentially?

LARRY ENGELSTEIN: Yes… [cross-talk]

COUNCIL MEMBER COHEN: So, so… but, but you don't administer your own plan?

SARA ROTHSTEIN: We do administer our own plan, I think what Larry is referring to is that sometimes there are confidential clauses and contracts between insurers and hospitals, some of those clauses might say I can't say for certain because we haven't seen the contracts, might say if you insure, want to include our hospital in one of your networks you have to include us in all of your networks so, if in… for example United wants to include Northwell in its Medicaid network it might not be able to exclude Northwell from a commercial network that we would use so we have flexibility to say here are the co-pays, here are preferred providers, we don't have full control over 100 percent of the network.

COUNCIL MEMBER COHEN: And DC 37 you use… you contract with someone for… to provide insurance to your members?

HENRY GARRIDO: So, the city of New York through the municipal labor committee which I'm the Co-Chair negotiates on behalf of all 456,000 contracts covering 1.4 million lives and we have a technical committee that we have a, a member of who meets with the different aspects whether its Emblem

Health as a primary care or any of the providers and their decisions to be made not unlike the BJ plan which is self-insured, we're not though the responsibility of paying on the bills is not just the city's, it's the unions too so over the years we have this very complex system since the physical crisis where there's a fund called a stabilization fund that city workers have foregone a lot of raises or even save in order to get that fund established and maintain that so there are no premiums so when people talk about city workers not paying premiums we are paying premiums we're just paying it out of different funds that comes out of the cost of wages and for us when those hospital bills and the surprise bills and the overage comes it's both the responsibility of the city and us to pay for those so instead of having discussions about wages or how do we improve productivity or how do we train workers to take over the job or how do we spend in developing the most skilled workforce in the country, right, we have to talk about how do we pay our bills because it's just the economic reality of the city budget, the city as an employer and us as a union because we provide supplemental benefits to which includes

prescription drugs, dental, all services, also some hospital bills as well so this is an issue that's effecting us differently than its effecting our brothers and sisters who have more flexibility as a self-insured plan but for us this is affecting everybody, every single city worker and their families so it… the, the system… there's got to be a primer to change what is happening now.

COUNCIL MEMBER COHEN: Thank you and I appreciate… I represent many of the… of your members and your members in my district so… I, I believe that there probably is a solution to the… to the out of network issue, that really seems to be… to be outrageous that with the technology we have that we can't just make sure that when you walk in the door that you're in a channel where at least you have a choice of I want to use the in network providers, you know throughout… for all the services I get. I appreciate your testimony, thank you Chairs.

CHAIRPERSON LEVINE: Thank you Council Member Cohen and I want to thank this panel for an excellent start to our hearing.

SARA ROTHSTEIN: Thank you…

CHAIRPERSON LEVINE: I want to call up our next panel which will include Andy Title from the greater New York Hospital Association and Leslie Moran from New York Health Plan Association.

[off mic dialogue]

CHAIRPERSON LEVINE: Welcome and as folks are filing out, we'll ask folks to please keep it down and Andy would you like to kick us off?

ANDY TITLE: Thank you. Good morning and thanks for the opportunity to testify on this important topic. I'm Andrew Title, I am the Assistant Vice President for Government Affairs at the Greater New York Hospital Association, we proudly represent all the hospitals in New York City and many others in the metro area and we appreciate the opportunity to talk and it's really important for us to continue the dialogue with the Council and with the public about issues that are important to the city and the state and the country. I want to start out by saying New York City's not for profit and public hospitals are open 24/7, 365 days per year, I want to point this out, they're committed to treating everyone who walks through their doors and no other providers can say this, hospitals are simply indispensable. I also want

to point out that hospitals serve Medicaid patients, the uninsured and provide the same quality of care to all. In 2017, New York City hospitals provided 3.4 billion dollars in Medicaid services and 988 million dollars in subsidized health care services. They're the biggest employers in New York City and I also want to add that we believe like you do in the Council and many others do in this room that health care is a human right. While for profit hospitals are becoming the norm in other states, New York institutions continue to pursue their not for profit and public mission which is caring for the most vulnerable. Hospitals face many challenges right now one of them is obviously rising costs which is the subject of this hearing. We agree that this issue must be addressed and its, its simply a fact that hospitals suffer from this trend as well. Hospitals pay for many of the things that are rising in cost right now that includes pharmaceutical prices, I heard people before talking about pharmaceutical prices and I don't know if they have anything to add to that, medical device costs, medical malpractice insurance is extremely high in New York State and that's something that all providers have to pay for,

labor costs are obviously high and then government mandates are causes of the reduce… that rising cost element too and it's something that we had to deal with too because we pay for all kinds of things that it takes to run a hospital. The other major challenge that hospitals are facing at this moment is reduced revenue. There are looming cuts at the state and federal level that I don't need to explain to you, you've probably been reading in the press lately about the Medicaid budget crunch that's occurring right now, and we're obviously very concerned about that. In Washington I don't need to talk about that either for a long period of time but obviously we have an administration that's hospitals in New York City, urban hospitals and hospitals across the country and it's a major, major cost, they're trying to undermine the affordable care act, there are looming dish cuts which are payments paid to hospitals that take care of the indigent and people without insurance and people with… and, and people on Medicaid those cuts are very concerning to us, we're hoping that they will be delayed, that's something we've been involved in Washington for a long time but right now that date is December 20th so that's

something very… we're extremely concerned about. And the other fact is that Medicaid and Medicare, the public programs while they're very important don't reimburse hospitals adequately for the services they provide and in New York City we have an enormous Medicaid program, that's something that's very important to us, that's something that we want to continue to invest in but the fact remains that that is a huge part of the payment base for New York City hospitals and it's one of the reasons they're struggling because they lose money on every single patient they see on Medicaid. I want to juxtapose this against some of the bad behavior that we're seeing from insurance companies right now that we'd seen for a long time and other people have talked about it previously. The denials of care are at record levels, our hospitals must negotiate with behemoth for profit insurance companies which have huge resources. Unlike our hospitals, who answer only to their patients and communities they answer to their shareholders. I want to go through some third quarter 2019 profits just to underline this point right here. United Health Care reported profits of 60.4 billion dollars; Anthem, Empire's parent,

reported profits of 1.2 billion dollars; CVS which now owns Aetna reported 3.9 billion dollars, these companies represent a huge portion of the insurance companies that provide care in New York City and New York State. These profits are larger than the entire annual budgets of many of our hospitals and health systems. These insurers are incentivized to provide a return to their investors, they drive very hard bargains and negotiations and then practices such as payment denials for medically necessary services, to avoid or postpone payments to hospitals as long as possible and this is one of the reasons, one of the biggest reasons that hospitals are struggling in New York State. The result is that 30 hospitals around the state are on a watchlist for closure, that's a list kept by DOH. New York has some of the lowest hospital margins in the country, they're around two percent and access to care is at risk around the city and state and these are very concerning trends, I think they should be for everyone because we do need to maintain our hospital infrastructure and hospitals do provide a great number of benefits to the people of New York City. This bad behavior effects consumers too and that's something that's been discussed a

little bit at the hearing already. They face much greater out of pocket costs as insurance companies deny care and employers shift to plans with high deductibles and co-pays. According to the Kaiser Family Foundation, from 2009 to 2019 average family premiums increased from 13,000 dollars to 20,000 dollars that's a huge amount. At the same time deductibles rose 160… 160… 62 percent far outpacing average earnings. This has obviously caused a burden for consumers and also increased bad debt for hospitals. In closing I want to talk about some of the solutions that we support and things that we've supported in the past. The first is New York's landmark out of network or surprise billing law, that was discussed obviously on the previous panel and I think that we'd agree with, with much of what was said although I just wanted to add a little bit on this. The law is one of the strongest in the country in protecting consumers from unexpected bills, the state department for financial services has, has determined it was a resounding success and we believe federal proposals should hold consumers harmless in out of network situations and follow the New York model. Council Member Reynoso I think was very

eloquent in talking about the challenge that he faced when he got an out of network bill ten years ago. Today that situation should not happen because of the New York State out of network law and if it did happen he would obviously have recourse, he would only be responsible for what he would have paid at an in network hospital; copays, deductibles which should be relatively low. The one exception to that and obviously this comes into play when we're talking about plans that are regulated by the federal government is ERISA plans or self-insured plans, Taft Hartley plans things like that. The state law does not apply to that. What Miss Rothstein said about them possibly opting into the state law that's something that I'm… I don't have expertise in whether they can opt in or not, I'm not sure but what they're talking about in Washington right now would basically fix that problem, they have the power to regulate and to legislate on the issue of surprise bills for those ERISA plans and we're campaigning in Washington supporting a, a measure that would hold consumers harmless and we believe that they should actually go and follow the New York model because it has been very successful and I'm happy to answer more

questions about that if, if you'd like. The second is New York financials… is New York's financial assistance law, it requires hospitals to provide aid to individuals who make less than 300 percent of the federal poverty, poverty line and have exhausted benefits or are uninsured. Many of our members exceed these requirements and provide more generous financial benefits, counseling, things like that. In 2017 New York State hospitals provided 600 million dollars in financial assistance. The third option for addressing cost is improving the affordable care act. Options include increasing subsidies to buy insurance, restoring the cost sharing reductions to help people fund premiums and creating insurer risk protections, there are obviously many more choices there that we, we support but those are just a few. The fourth is insurance reforms. We need to cut down on the huge amount of denials of coverage by for profit insurance companies. We also support state action to cover undocumented residents and we support a bill that would basically expand the state's essential plan to cover those individuals by… emergency Medicaid. I believe Council Member Adams has a resolution in support of that state bill and

we've issued a memo on that. Finally, and I… and I don't think I could say it better than Mr. Garrido here, we really need prescription drug reforms because those costs are simply out of control. Like the insurance industry, pharmaceutical companies have exploited vulnerable individuals that depend on these drugs and government should take steps to bring these costs under control. That completes my testimony, thank you and I'm happy to answer any questions.

CHAIRPERSON LEVINE: Thank you very much Andy and we have I think a fuller testimony from you in writing here that we want to enter in the record and we appreciate you giving us the, the highlighted version and we'll pass it off to you Leslie now.

LESLIE MORAN: Thank you. My name is Leslie Moran, I'm Senior Vice President of the New York Health Plan Association, we're a not for profit organization that represents 29 health plans across New York State that provide coverage to nearly eight million fully insured New Yorkers and millions of others that are covered under self-insured or risk plans. The people that are served by HPA's member plans include individuals who receive coverage through an employer or who purchase it on their own

directly through a health plan or through the New York State of Health, the exchange. We also cover residents that are cover… or represent residents that are covered by state programs that include Medicaid, child health plus programs, the essential plan and managed long term care and we thank you for the opportunity to be here to discuss this very important topic about health care costs. HPA's members are committed to the goal of universal coverage, we have a long history of working collaboratively with New York government and other stakeholders in implementing both the affordable care act and working on achieving the goals of the state's very ambitious Medicaid redesign program. This common effort is a major reason that New York has been successful in ensuring, ensuring coverage for more than 95 percent of state residents today reducing the number of the uninsured from ten percent in 2013 to less than five percent today. Keeping health care affordable is the number one challenge that faces all of us, rising health care costs remain the pressing health care issue that faces employers, consumers and state government. You've covered a lot of the cost of care and, and some of the national figures about how much

we're spending on cost… on health care so I'm not going to repeat all of that and most of its in our written testimony and as you've already noted New York has some of the highest health care costs in the country and its markedly higher here in New York than the national average. We have a couple of charts in our testimony that show that, that… its actually the prices of health care that continue to go up not necessarily utilization and so that's, that's what I would like to turn to and address some of that at this point. When we talk about costs as you've heard here and as you've pointed out people are also often talking about what health insurance costs or what their premiums cost but what we can't ignore is that health care premiums and medical costs are inextricably linked, the cost of coverage is driven by the cost, the underlying cost of care and while every New Yorker deserves access to high quality care making that reality requires addressing these underlying factors that drive up health care costs, you've heard some of it today and I'm going to talk about prescription costs but one of the, the biggest drivers is provider price growth and again we have some charts that show that provider prices are going

up even though utilization of provider services both hospital inpatient and outpatient services and doctor services actually not going up at the same rate. One thing that's driving this is, is provider consolidation, we have seen and continue to see numerous mergers, acquisitions, clinical affiliations between hospitals, physicians and other providers and while there have been some suggestions that these delivery system changes will result in better integration of… and better… improved quality of care for patients. There's a growing body of research that shows it's not necessarily the case. In fact, instead of better care and lower prices many of these arrangements merely lead to enhanced bargaining powers for providers when no notable improvement in the quality of care for patients. We believe that government can and should take some steps to promote greater accountability of these provider transactions, this would increase… include increased provider transparency or excuse me, greater transparency of provider costs, also it would… we would recommend restricting some of the contracting practices that harm consumers and employers. There's greater detail on some of these steps in my written

testimony but you've also heard from 32 BJ. One of the things is a lot of clauses currently prevent tiering and steering so we insurers are not necessarily allowed, or they're precluded from being able to steer patients towards higher quality and sometimes lower, lower cost providers. There are also some of the other contracting clauses that Sara alluded to where plans are required to include hospitals in all of their product lines so there's… you know there's a… kind of a… all or nothing clauses that we would recommend you take a look at and, and do something about. Turning to drug prices, there's no argument that advances in the development of life saving medications offer tremendous clinical benefits for patients however rising prescription costs and prices are a major threat to keeping health care affordable. There's a chart in our testimony that looks at the rising cost of, of drugs from 2011 to 2018, many of them are common drugs that have been on the market for years and yet we see huge increases in prices. One example is doxycycline which has gone up over 600 percent in that time period. Its unclear that these prices… price increases are justified or that we're getting any benefit from them. An October

report from the Institute for Clinical Economic Review also known as ICER which is an independent nationally recognized research organization examined whether certain price increases are justified by new clinical evidence or other factors. In analyzing pharmaceutical manufacturer prices, price increases on seven widely used drugs in 2017 and 2018 ICER found that the price hikes resulted in an additional 5.1 billion dollars in spending for insurers and consumers and they found that there was no new clinical evidence that would support those price increases. While we recognize that there's a value to prescription drugs, we believe that break through medication should not be a blank check for the manufacturers. Out of pocket costs are dictated by list price of a drug and the list price is solely determined by the drug manufacturer. As consumers, employers, providers and health plans and the state grapple with rising prescription drug costs a greater understanding and greater transparency is needed about how these prices are set and the rational for increases. So, we would recommend that there be and we actually have worked with the state legislature… the state legislators to introduce some legislation

that would require greater transparency and greater information be given to consumers on what drugs actually cost and when prices are going up that they get some fair warning, early warning for that. Finally, I just want to talk for a moment about government taxes, fees and assessments; these add to the cost of coverage for New Yorkers, the state currently collects nearly ten billion dollars annually through the health care reform act or HCR. These assessments include the patient services assessment which is essentially a sales tax on inpatient and outpatient hospital charges and numerous other health care services at the site of delivery., And then there's a covered lives assessment, this is a tax that's placed on every policy that is sold in New York State. These HCR taxes represent the third largest source of state revenue behind the sales and income taxes, they are in addition to other state taxes and fees that our built into the premium that we pay for our health insurance. Talking about taxes, the affordable care act, while it has had significant impact on expanding coverage for millions of New Yorkers, there are also taxes that are associated with the ACA that drive up

the health… the, the cost of health insurance as well. For example, the ACA established an annual fee on health plans, another sales tax, the so-called health insurance tax, its similar to the covered lives assessment and it's a direct sales tax on health insurance. While there's currently a moratorium on this tax that moratorium will expire at the end of this year and it will result in an additional one billion dollar in cost for New York in 2020, included in that is 150 million dollars in additional costs to the Medicaid system which you've heard at… has been discussed we're facing a four billion dollar deficit in Medicaid so 150 million dollars on top of that is not going to help the situation. As I said there's currently legislation to extend the moratorium through 2021, we would urge you to encourage your New York congressional colleagues to support and pass this important bill and I'm happy to answer any questions.

CHAIRPERSON LEVINE: Thank you so much Andy and Leslie. Leslie how many of your members are for profit insurance companies?

LESLIE MORAN: We actually… I can't give you a specific breakdown without doing… counting them

on my… looking at my list but it's a fairly even split between for profit and not profit… not for profit and I would like to remind, remind you what your, your colleague, Chair Rivera had said, we have laws on the books both federally and state laws that require a percentage of the premium to be spent on health care services so we know that in New York State 85 percent of every dollar spent on health care… or of the premium has to be spent on health care.

CHAIRPERSON LEVINE: But when you spend money on advertising, administrative costs and other non-medical expenses…

LESLIE MORAN: That's part of that… of the administrative costs, that's… [cross-talk]

CHAIRPERSON LEVINE: So, that's got to be… that's not counted towards your 85 percent obligation?

LESLIE MORAN: No, the, the 85 cents of every dollar has to be for direct medical care; hospital costs, pharmaceutical costs, doctor reimbursement, etcetera.

CHAIRPERSON LEVINE: Explain to me how it is that your for-profit members continue to rack up

multibillion-dollar profits, why, why is there not competition to drive that down in the form of lower prices to consumers?

LESLIE MORAN: Well the money that the companies make is off of their investments is not factored into the premium costs, I mean that's the… that's separate and apart so when we're talking about the profits or what plans are making its generally not… it's, it's not money that is being taken away from the… from the members and its not money that they're paying in premiums… [cross-talk]

CHAIRPERSON LEVINE: But but premium and deductibles are, are skyrocketing and they have for a decade or more.

LESLIE MORAN: But that's directly related to the under… the, the cost of care that I'm talking about, the prescription drug costs, the provider costs, it has… that… the money that goes to shareholders is not factored into premiums.

CHAIRPERSON LEVINE: And, and I am sorry that there's not a rep from the pharmaceutical industry here, we've been pretty clear in, in, in our criticism of the extortionary prices they are charging on drugs that people have no choice but to

purchase and I laid out some of the diseases where this is actually impacting the ability of patients to achieve care so I'm not letting them off the hook but normally when you have… when a consumer has the ability to pick where they want to turn to for a product or a service… [cross-talk]

LESLIE MORAN: Uh-huh… [cross-talk]

CHAIRPERSON LEVINE: …that gives the consumer some power and that drives down prices and prevents undue profits. Somehow that's failing in the insurance industry.

LESLIE MORAN: Well we actually… as I said we have worked with legislator to introduce two pieces of legislation that would require greater drug transparency or greater transparency on drug pricing. The… sorry, I lost my train of thought there. The… part of the problem we have… health insurers their premiums are highly regulated by the Department of Financial Services, they have to actuarily justify every single cost that's built into the premium so… and right now when prices of drugs go up in the middle of the year there's no ability for a health plan to adjust for that so we would like to see greater transparency on the part of… I mean greater

accountability on the part of drug pricing and the pharmaceutical industry for what it's charging for these drugs. We also have problems and have worked with, with state lawmakers and regulators to try and steer people towards lower cost options whether again its through tiering, right now plans can have three pharmaceutical tiers, we have actually talked about having a fourth tier that would be like a zero co-payment for generic drugs but the Department of Financial Services has not allowed us to have that kind of flexibility that would give us greater ability to, to provide relief to consumers on prices.

CHAIRPERSON LEVINE: Right. Thank you. And you know when, when a consumer shops for almost any product imaginable even those that have all sorts of complicated varieties and permutations and, and specs they can engage in price comparison and they can make an informed decision about where they get the value they're looking for, where something is affordable given their economic constraints that seems to have totally broken down when it comes to getting medical care, why can't we simply have clear, consistent, transparent pricing so that consumers know what they're in for before they're coming out of

the hospital and being handed a bill that they have no way of, of affording?

ANDY TITLE: Thanks for the question. I think the first thing I would say is that this is a really complicated problem, that there are a lot of players involved but that we do support price transparency, the issue is just how you do it. I think when you talk about a specific situation, a specific consumer's experience it could vary widely. If you have somebody who doesn't have insurance then there's one set of factors that's going to happen, most people have commercial insurance, if they're trying to figure out what something is going to cost obviously the hospital has a, a role to play in figuring out what that cost is going to be but the insurance company has a tremendous amount of… to do with that also. So, if a consumer goes to a hospital and says I want to estimate these costs there might be information that a hospital may not have and an insurer may have that could actually go ahead and… you know to figure out what that's going to be. If you're talking about a self-insured plan it might be a different situation so I would say that health care is really complicated, we don't always know exactly

what's going to occur in a hospital, what complications are going to occur so you can have… never have 100 percent transparency or certainty about costs but that's something that we all want to work towards and I think that really needs to be a collective conversation.

CHAIRPERSON LEVINE: A recurring theme here has been the challenge of out of network providers and you can understand that a patient comes into a hospital that's in the network and only later learns that some component of the providers were not in network and the cost can be exorbitant, sometimes the cost is ultimately born by if they're a labor union member by the union itself. Why can't you just require that every provider in one of your hospitals be in network?

ANDY TITLE: Yeah, also good question, this is something that I think I'm learning more about. I would say that, you know I have heard of hospitals that are sort of experimenting with different policies on this issue and actually requiring providers to be part of their networks, it's not something that's easy to do and obviously physicians are people that are highly educated and in

demand, we don't necessarily have a sufficient amount of them and there would be consequences to actually requiring that and I'm not sure which laws would actually be, be pertinent here but I don't think it's quite as simple as a hospital saying that everyone has to be in network to be in the hospital, the hospitals do work really hard to make sure that people are in network and I think that we're committed to working towards finding solutions on this issue too. The, the other thing I would say is that in emergency situations and, and maybe I'm repeating myself here but in emergency situations or surprise bill situations consumers regulated by state plans, state regulated plans, consumers with insurance from state regulated plans they are protected in those situations and even before this latest surprise bill law was passed in Albany they were protected and they would… they were only responsible for their in network copays and deductibles in that situation, the only thing that the law said was that the insurance company had to hold their individual policy holder harmless.

CHAIRPERSON LEVINE: Is it not true that perhaps this is a national… at the level of national

hospital lobbyist but that you're suing to prevent some of the transparency legislation from taking effect?

ANDY TITLE: Greater New York isn't I think the AHA is, American Hospital Association.

CHAIRPERSON LEVINE: Of which you're a member?

ANDY TITLE: Yes.

CHAIRPERSON LEVINE: Why in the world would they do that given the values that you just put forward?

ANDY TITLE: I think we have some serious concerns with the way that policy has been laid out as we do with many other policies that the Trump administration has put out there, I think the actual information that they're asking to be disclosed we question the value of it to the average consumer because it is enormously complicated, there's also a tremendous administrative burden that would present to hospitals. Some of the people who work on this data have told us and this is in some of the articles that are out there that the actual excel files wouldn't even… would just be massive and the amount of information would be hundreds and hundreds and

hundreds of columns wide so those are the reasons we oppose it.

CHAIRPERSON LEVINE: There's been a lot of really frightening reporting about the dramatic increase of use of the courts to collect medical bills, hospitals essentially suing patients, could you explain why the… your sector is, is resorting to this incredibly aggressive tactic?

ANDY TITLE: Yeah, the first thing I'd want to point out is that some of those articles have been about hospitals all around the country and I think that its important that we look at what's actually happening in New York State because we do have this financial assistance law, I'm not saying that that never happens but obviously we have one of the more generous ones around the state and… or… and actually in the entire country and generally speaking hospitals are very reluctant to sue patients and do that as a last resort.

CHAIRPERSON LEVINE: Are you willing to, to share the costs that, that private insurers are charging you so that we have some sort of comprehensive comparison?

ANDY TITLE: So, Greater New York generally doesn't have that data because we're the trade association for the hospital… [cross-talk]

CHAIRPERSON LEVINE: So, it would be your… [cross-talk]

ANDY TITLE: …so, it, it… [cross-talk]

CHAIRPERSON LEVINE: …that would be an ask of your members then… [cross-talk]

ANDY TITLE: …it would be an ask of our members. I would say that I was just looking at a study and its quoted in my… in my testimony that the prices private insurers pay New York hospitals are about the third lowest in the country, that's a RANDY TITLE report, obviously it depends a lot of different ways how you look at this but I think it's just important to point out that they're… this is a complicated issue and the scholarship on it is important to look at.

CHAIRPERSON LEVINE: Right. Since, since you, you, you have explained that you share concerns about increasing costs, what steps are your members taking to control costs, to reduce costs, to stop these endless increases?

ANDY TITLE: Sure, and some of this in my testimony so if I forget something forgive me. I think the first thing I would talk about is the delivery system reform incentive payment program, DSRIP which… talked about a lot, the goal of that project is basically to cut hospitalization by about 25 percent in patient hospitalization and that's a goal that we haven't gotten to completely but I believe the latest number that we're at is one percent off. Another thing I would mention is the hospital billing, we have seen a proposal that Mr. Gottfried in the state assembly and Senator Rivera put out there on medical billing, I think it's something that we're looking at very closely and we think that we can get to a yes on a lot of those things, there are some challenges but we're always looking at hospital billing and trying to reduce that, those are two of the things that I… [cross-talk]

CHAIRPERSON LEVINE: So, you're actually supportive of the Gottfried bill?

ANDY TITLE: I think they're… we have different positions on different, different aspects

of that bill and we're continuing to redo… to review it.

CHAIRPERSON LEVINE: Okay. Understood.

[off mic dialogue]

COUNCIL MEMBER RIVERA: I, I do have a couple questions for you but I'm, I'm going to allow my colleague Council Member Cohen to ask questions as a favor.

COUNCIL MEMBER COHEN: I, I appreciate that Chair, I'm going to be very brief. Thank you both for your testimony, I don't want to weigh in on the, the battle between the hospitals and the insurance companies but I am curious because based on the… on the, the testimony of the last panel about the out of network law that's applicable in emergencies only?

LESLIE MORAN: No.

COUNCIL MEMBER COHEN: It, it… either one.

LESLIE MORAN: There, there are a couple of provisions and Elizabeth is here and also chime in, I'm sure she will later but the, the… New York's out of network law protects patients against emergency balance billing and also balance… being

balance billed for care provided by out of network providers.

COUNCIL MEMBER COHEN: So, if I go in though for a scheduled procedure and it… my doctor is in network but it turns out my… the anesthesiologist is not for a scheduled procedure am I… am I covered by the New York State out of network law or not?

LESLIE MORAN: The charges by the anesthesiologist could be disputed and taken to… there are a couple of processes, you… the, the consumer could say I didn't realize this was an out of network provider and turn to the plan and say I'd like to dispute this and then the plan will dispute it on behalf of the, the, the member. What they do is they first talk with the provider and try and reach an agreement between… that… somewhere between what the charges are and what the insurer would pay, if they can't reach an agreement then it can be sent to an independent dispute resolution process an, an, an… you know an independent arbitrator would decide.

COUNCIL MEMBER COHEN: So, the patient could lose that, that, that… [cross-talk]

LESLIE MORAN: No, the patient is held harmless.

COUNCIL MEMBER COHEN: The patient is held… [cross-talk]

LESLIE MORAN: Harmless.

COUNCIL MEMBER COHEN: …harmless. So… okay, I, I understand.

LESLIE MORAN: That was the, the main goal of the out of network surprise billing law of 2015 was to protect consumers against these egregious out of network bills both on the part of hospitals and providers.

COUNCIL MEMBER COHEN: I understand, I appreciate that. To, to… just so I understand, I mean hospitals ultimately… I mean the service provider is the ultimate driver of what the cost is going to be, it's… I mean you know while there are a myriad of costs in the system, you know what I… you know you determine what the cost is for an appendectomy not, not the insurance company, not the…

ANDY TITLE: Yeah, I think that I would agree that the hospitals are the primary driver of the underlying cost but the cost to the consumer is going to be filtered through their insurance company and that's something that is very different… [cross-talk]

COUNCIL MEMBER COHEN: Can, can you just talk though a little bit about what the drivers are in the increasing… you know what's driving up the cost in terms of actually providing the services?

ANDY TITLE: Sure, I think that… there were some of the things that's mentioned in my testimony so obviously we'd be talking about labor cost, we'd be talking about insurance company denials, we'd be talking about uncompensated care, the fact that Medicaid and Medicare do not reimburse an adequate amount for hospitals to break even on those patients, those would be the primary things, of course pharmaceutical costs, regulatory costs, medical costs… [cross-talk]

COUNCIL MEMBER COHEN: You, you amortized the cost… like my appendectomy pays for people who don't have… who are… the uncovered patient, a portion of that.

ANDY TITLE: I think that you're referring to what we call the cost shift, correct Council Member?

COUNCIL MEMBER COHEN: I think its… yes.

ANDY TITLE: Yeah… [cross-talk]

COUNCIL MEMBER COHEN: I don't know…

ANDY TITLE: Yeah… no, I'm, I'm… yeah, I mean I think that's true, basically the state and the federal government haven't stepped up to the plate and actually paid hospitals what it costs to deliver care, before the latest rate increase New York City hospitals got and New York State hospitals got and that's something we push for with 1199 SEIU, United Healthcare Workers East, we push for a two percent increase, that was after ten years of zero growth in Medicaid so as inflation goes up medical inflation, labor costs, all things like that, negotiations, all of that was going up but Medicaid rates are staying the same and that's in our view the biggest reason that hospitals around the state are struggling. We were very happy to get that two percent increase which we did not think was unreasonable but now we're seeing that Medicaid rates could get cut again and that could get completely wiped out so I think it underscores the really fragile state and position of hospitals in New York State right now.

COUNCIL MEMBER COHEN: Could you also… my last question just talk a little bit about and I realize it, it is a small percentage of the overall health cost pot but executive compensation your

member hospitals particularly the… you know the most senior management?

ANDY TITLE: Sure, you know I think executive compensation obviously needs to follow guidelines when the IRS puts things out… puts information out on that and they have the power to assess that, the other thing I would say is that hospitals are really hard to run especially in this day and age and hospitals are competing with other states that are… have for profit hospitals or fewer restrictions on executive compensation to actually get those individuals so we do need to attract individuals that know how to run hospitals and I don't think that it should be completely out of whack but there is that compensation dynamic in there…

COUNCIL MEMBER COHEN: I will say as an average New Yorker it is… it is hard to comprehend why the head of a not for profit hospital makes millions and millions of dollars and you know we, we… through a variety of government supports keeping these hospitals, it, it is very hard to understand. I really do appreciate the curtesy Chair, thank you.

COUNCIL MEMBER RIVERA: Thank you so much. So, just a couple of questions because I know

you've, you've been here for a while. So, denials of health care are on the rise, people face utilization reviews, prior authorization and how are patients informed of their appeal rights if their insurance company denies coverage of their care?

LESLIE MORAN: So, there are state laws in place that require you to notify a patient when they have had an adverse determination which is a denial of care and give them the opportunity to appeal that so there are internal appeal rights and there are… if those are exhausted and they're still found that a service is medically unnecessary for whatever reason then there are external appeals processes as well and the actual final determination of… on the internal appeal must be accompanied by notification of how to file an external appeal and we've been very supportive of the external appeal law and in fact it, it has worked quite well we believe to the benefit of consumers to make sure that they're getting the appropriate care and access to medically necessary coverage.

COUNCIL MEMBER RIVERA: Do you have data on how frequently that occurs?

LESLIE MORAN: It's actually not as frequent as you might expect, the number of external appeals, I don't have the most current data but it's… we're talking about maybe several thousand cases if that a year and when you're talking about millions and millions of New Yorkers who are covered by insurance and you know government programs that can avail themselves of these appeals processes the, the denial rates are actually quite low.

ANDY TITLE: Can I just add something to that Council Member?

COUNCIL MEMBER RIVERA: Uh-huh…

ANDY TITLE: I would say that in many situations when care is denied, and a hospital has delivered it or a provider that provider is on the hook and that's something that adversely effects hospitals as well.

COUNCIL MEMBER RIVERA: How… [cross-talk]

UNIDENTIFIED FEMALE: What about patients?

COUNCIL MEMBER RIVERA: What about the patients, yes, good question?

ANDY TITLE: Well it depends on the situation but usually or in many cases the hospital

wouldn't necessarily bill that individual for that service.

COUNCIL MEMBER RIVERA: How many insurers in New York State have cost calculators available for their enrollees?

LESLIE MORAN: I believe it's actually a requirement that all plans have cost calculators, some of them vary in, in terms of sophistication I believe but all of them have some sort of a cost calculator, a lot of them actually contract with Fair Health to provide cost calculators so information is available to consumers and in addition to cost calculators that might be on a website or available in other ways plans also have member services departments that can help walk people through and help them get that information so there are a number of avenues where they can get information about what their costs are going to be.

COUNCIL MEMBER RIVERA: And, and I, I know that they're supposed to be available but there is… when you look at something like statewide planning and SPARCS data, right on discharge costs and then there's the sticker price versus what's

actually paid, there's a lot of ambiguity and there's a lot of discretion which I… [cross-talk]

LESLIE MORAN: Uh-huh… [cross-talk]

COUNCIL MEMBER RIVERA: …I think is what this hearing is really getting to so how do you make costs clear to your enrollees?

LESLIE MORAN: Well I can't speak on… for specific plans but in general this information is available, again under the out of network law you have to be… plans are required to have information and, and do cost calculations for members when they seek out of network care, there has to be some information provided on what their… what their out of pocket, what their… what they will be on the hook for. As you indicated some of the data that is available to do those cost calculations is, is difficult at best and that is not… that's data that we don't control, that the plans don't control, we don't know what the hospital charges necessarily are going to be and as my… gentleman to the right has pointed out they find that very difficult to provide so it's not something that's within the plan's control to provide, it's kind of… falls under the umbrella of what I would say is you don't know what

you don't know so if a plan doesn't know what the hospital is going to be charging its very hard for them to be able to tell the consumer what their 80 percent… or what their 20 percent responsibility might be, there's some variables that they don't have all the information about.

COUNCIL MEMBER RIVERA: So, you could… you could go on to the cost calculator, you could get your estimates, it could be close, it could not, that's the biggest issue I think we're facing here but how do insurers guide their enrollees to in network care?

LESLIE MORAN: Well they have… [cross-talk]

COUNCIL MEMBER RIVERA: And how… and I just want to know how clear are your networks?

LESLIE MORAN: Again there are state requirements for network adequacy and requirements for provider directories so plans have to list exactly who is in their network and they have to have an adequate number of providers of, of particular types, adequate hospitals within a service area and all of that is contained within the provider

directory information that's available to members… [cross-talk]

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

LESLIE MORAN: …and plans do try to steer patients to in network providers making them aware that their cost responsibilities are likely to be less if they go to an in network provider than an out of network provider but there are times when a patient may still want to go to the out of network provider.

COUNCIL MEMBER RIVERA: I, I think our issue is that they're famously inaccurate so we, we want to make sure that we're bringing these real prices for people to set their expectations to the financial cost, I know you want them to understand what they're about to embark on in terms of what could happen to their household… [cross-talk]

LESLIE MORAN: Uh-huh… [cross-talk]

COUNCIL MEMBER RIVERA: …with receiving one of these bills so for hospitals why is it difficult to, to list the sticker price and, and what is the data reported to SPARCS?

ANDY TITLE: On the data reported to SPARCS I would have to get back to you on that because that's just not my expertise, when you're talking about listing the sticker price could you explain more of what you… what you mean by that?

COUNCIL MEMBER RIVERA: It's the cost versus the charge because in… there's the sticker price and then what is actually charged for it.

ANDY TITLE: The negotiated price with the insurance company. Well hospitals are negotiating with a huge number of different plans, those would be commercial plans, they would be the benefit plans, all kinds of other plans and within those plans there are a variety of products that could have different negotiated prices so there are quite a large number of those negotiated prices but hospitals should know what those negotiation, negotiated prices are.

COUNCIL MEMBER RIVERA: Thank you, I, I… you know I, I realize that things are complicated and difficult but it's… you would have to be a literal expert to really figure out what you're going to be charged for, what you can pay, what's the national average and its really difficult, it's really difficult and, and in a city with this much wealth

that we have so many disparities so we just ask and I thank you for answering our questions and, and for being here that you keep the patient at the forefront of your mind in making these decisions and that you also help some of the advocates and the people in this room make sure that we also have representation and a voice at some of our highest levels that make these decisions on hospital consolidation, you know we, we… we're dying for a, a consumer voice at the FPIC table for example and it's just taking… its been a long unnecessary road and I see some of the names that are on this board and, and I realize that they are parts of major entities that are important to the conversation but we, we need to have the average person and consumer also be very, very clear as to what they're going through. So, thank you for being here and thank you for your testimony… [cross-talk]

LESLIE MORAN: If I could just address that.

COUNCIL MEMBER RIVERA: Sure…

LESLIE MORAN: We agree with you on the FPIC issue and I would note that there's only one health plan representative on that board as well and fortunately although the Governor recently vetoed

legislation that would have increased the number of, of members on FPIC, he did… he did in his veto message say that he wanted more consumer representation which we, we 100 fully support.

COUNCIL MEMBER RIVERA: Well I, I hope that you're right and I hope that you'll help us with that issue and, and thanks again to the both of you for spending the time here and waiting and answering our questions.

LESLIE MORAN: Thank you.

COUNCIL MEMBER RIVERA: I'm going to call the next panel Elisabeth Benjamin, Community Service Society; Naysha Diaz, Planned Parenthood; Patrick Kwan, Primary Care Development Corporation and Anthony Feliciano, Commission on the Public Health System and thank you all for your patience. You can go ahead.

[off mic dialogue]

COUNCIL MEMBER RIVERA: Whatever order you'd like, why don't… why don't you start, you've been here since the beginning.

ELISABETH BENJAMIN: Hi, good morning. My name is Elisabeth Benjamin, President for the Health Initiatives at the Community Service Society of New

York, thank you Chairwoman Rivera for hosting this hearing, I think it's on a really important topic. I'll try to keep my comments super short because I'm sure you want to have lunch and everybody else here probably wants to go too. So, I just wanted to let you know that the Community Service Society serves about 150,000 health consumers every year, we're very proud of that number. In fact, we just hit our millionth consumer served a couple of months ago so we're, we're trying to take on McDonalds. In… during each year our community health advocates program, our sort of flagship program that helps consumers with hospital bills, insurance bills, problem… you know insurance appeals like the external review process and I think there's 10,000 a year but I could be wrong about that but we serve around 30,000 consumers a year. What we have noticed in the last year is a 46 percent increase in medical debt cases. So, something is happening and its really horrible for patients. Health care affordability is out of control, we did a statewide poll of 1,000 consumers in January, we could dissect the polling by New York City, Long Island and upstate, in New York City alone 79 percent… or sorry, 59 percent of consumers had had a

health care affordability problem, what's that problem? Cutting their pills, self-rationing care, skipping or not going to treatment, all of this is in my testimony so I'm not going to go on and on about the statistics. What I would like to say is that it's really important to know that about a third of all consumers polled, not in this poll but a different one, pay their bills for fear of having their credit ruined even when they think the bills are wrong so people are paying because they're terrified. Why are they terrified? And I wish Mr. Title was still here, I'm not sure if he is, I think he left…

[off mic dialogue]

ELISABETH BENJAMIN: Oh, good because this is what's happening, we have just surveyed so far eight counties in New York and we found almost 20,000 court cases being brought against patients, right now in New York State, that's a problem. When you look at these hospital court cases, let's just take Queens, in Queens alone there were 3,600 cases, I think Miss Rothstein was talking about Northwell, 70 percent of those cases were actually being brought by Northwell. So, something is deeply wrong about these so called nonprofit behaviors because that's a…

and what are they suing for, they're suing for nine percent interest per annum, that is not a nonprofit rate, the federal fund rate is around two and a half percent, that's a nonprofit rate. So, if you're a nonprofit you have no business suing anybody for nine percent interest. Okay, it's not the credit card rates but come on, you know it's not okay. So, when we talk to our consumers its sort of at this point a pox on all of their houses and we never saw these numbers before, we always know… no, no offense Leslie but we always thought everybody hates their insurance companies, right, you know everybody hates pharmacy but now everybody hates hospitals too and that's because the behavior that's happening at hospitals is not okay, even our beloved New York State nonprofit hospitals and we're proud that we're nonprofit state… hospitals in New York State. So, skipping to the… you know we would love… we have some coverage options, we're delighted that Greater New York is supporting coverage… expanding coverage to immigrants, thank you, we're delighted… we also know the health plan association is doing that and we have some real coverage fix that could really help people but moving to what's really happening on this cost side, that's

what happens to real patients right now and we're really delighted that Mr. Title said that they would consider looking at the bill that's currently pending in the state, state legislature, it's 8639 assembly, 6557 in senate, it's called the patient medical debt protection act and why do we need this? We need this because patients are getting sued, we need this because patients are being called this sort of so-called resort fee… actually it's called a facility fee but its really a resort fee, it doesn't pay for any medical service. If I go to you Anthony, you're my doctor and you don't give me a service… you don't give me a band-aid called facility fee, you… there's no… there is… you don't sew me up for a facility fee, that's not okay. The hospitals are not… we, we understand another component of that law is to the have the hospital required to submit their data to the all payer claims database that New York is very slow in developing, Maine has one, New Hampshire has one, Oregon has one, I mean these are not like the leading light of health care, no disrespect but you know we think New York is the leading light of health care. How come we can't have an all payer claims database but we understand and we would like you to

find out if it's true, is we understand that some hospitals, some of our beloved nonprofit hospitals tell the insurance companies that they're not allowed to resort… report their data, well that's not okay. Why is that contract even legal? So, we're saying that New York State should make such a contract, such proprietary information illegal because we spend billions on our beloved hospitals. Mr. Title said we give out 600 thousand… million dollars a year in financial aid, well they get 1.2 billion dollars in indigent care pool funding, I would like someone up there to ask… bring him back and ask him where's the other 600 million, where did that go to? I mean honestly, we… so, one… another provision of our bill would in… would fix the financial assistance law because it… why? Because it doesn't cover the doctors that the hospitals have contracts with and allow to operate out of their hospital those guys aren't covered by the hospital financial assistance law so if you apply for financial aid, aid and were lucky enough to get some of that 600 million dollars applied to your case it doesn't help you with the, the whole issue we're here for now, it's just a surprise bill, right, it doesn't cover the doctors.

Now some hospitals I would like to say have stepped up and said we do want to cover in… our providers, Columbia Presbyterian but not while New York Presbyterian doesn't, NYU is trying to do it so its… you know it's, it's a mixed bag, I would have to say that Health and Hospitals has really stepped up on this whole collection act, activity and decided that they are renouncing the practice of suing their patients so good for them, I'd like to see every single other nonprofit hospital in New York State do the same, you know you… Virginia did, there's four other major hospitals around the country that have; Health and Hospitals had… let's start a petition, I pledge I won't sue my patients, that's a nice pledge or if I do I do it on a timely basis and not for nine percent interest compounded per annum. Okay, so I'm going to stop because… and the other thing is we… you know there's… we want this whole… there's a package of… its an omnibus bill, it's seven packages, it makes billing more simple so people can actually understand it, it, you know gets rid of the resort fees or at least when the insurance companies won't pay for them, if insurance companies want to pay for resort fees that's up to them and it… also just one

last other practice that I think would be really great is a lot of people and you all probably have done it yourselves, you go to the doctor, they're like oh sign all your HIPAA releases and then there's one more form now and it's the patient financial liability waiver form where you promise to pay everything that your doctor bills for even though you don't know what they're going to bill, what tests they're going to order or whatever. Now I am a recovering lawyer, I call that a contract of adhesion, that's an illegal contract, patients have no expert knowledge, you can't just sign away your rights for some… unspecified set, set of services and yet these things are everywhere now. Finally, what can the New York City Council do about any of this? Well honestly a lot of this is in the hands of the state legislature but there are really important things you can do and the most important thing is what you proposed Councilwoman Rivera which is to set up that patient advocate, how come that hasn't been enacted yet, I mean not that I'm allowed to ask you questions but… I would… no, I'm sorry but you know I would like, like… why… that was… you know you proposed that almost a year ago, let's see some

movement on that, what can we do to help you move that because if we had a hospital patient advocate in New York City maybe they could ask… maybe they could find out what are all the city tax benefits we're providing our beloved nonprofit hospitals and maybe figure out a way to make them accountable for some of that, you know that would be like my first thing I would like them to work on. The other thing that you all have done which we're so grateful for and we hope you'll continue to fund in the future is the NYC MCCAP program which helps people, helps… you know it funds real community group, groups where people live and work to resolve these medical gap problems, insurance is hard, I mean Mr. Title said over and over again it's complicated, its complicated, its complicated well if it's so complicated let's give community members the help they need by funding NYC MCCAP so that they have help dealing with our so called complicated system if we're not going to fix it then let's at least give them some… a fighting chance to, to suffer through it. So, I thank you…

[cross-talk]

COUNCIL MEMBER RIVERA: Thank you…

[cross-talk]

ELISABETH BENJAMIN: …I hope I didn't take too long… [cross-talk]

COUNCIL MEMBER RIVERA: No, thank you for what you… [cross-talk]

ELISABETH BENJAMIN: …I don't know if I… [cross-talk]

COUNCIL MEMBER RIVERA: …said and I, I, I'm hoping the Office of the patient advocate can do a lot… a lot with… in terms of data and, and for what you mentioned on funding, you know we had a hearing on this funding and we're… and we continue to, to track these issues and that to me is, you know one of the greatest injustices of, of our public health system but thank you so much, Mr. Feliciano.

ANTHONY FELICIANO: Good afternoon, my name is Anthony Feliciano, I'm the Director of the Commission on the Public's Health System. I also have a long testimony but I'm not going to go through all of it. I'm also in… and congruent, in agreement with Elisabeth on many aspects. I think there was a lot of conversations about many factors, right, that increased cost, doctors, hospitals, drugs, federal policies, some of the risk, adjustment, payment issues but I think there's some other underlying

issues that we all kind of hit on which is, we have a health care system that… political institution of interest care less about people and more about profits. We don't have real comprehensive health planning to address how our communities are getting sicker particularly the most marginalized. We have a widening wealth gap that's causing this too. We also have badly developed state policy decisions on the allocation and distribution of health care funds and many times to the wrong place. We have government processes like Medicare, Medicaid it faces… and its constantly being cut. We also have a growing older population that may need more medical attention, it's about 64, 64 percent of Medicaid spending is, is spent on older Americans and people disabled, this is some from the Kaiser Family. When you talk about rising costs of health insurance I put in some data that came from the New York State Health Foundation, I'm not going to go through it but I want to give you one service that's costly, dental care, oral care, its extremely expensive. Perhaps millions of, of seniors and children go without that needed dental care because they simply can't afford it. Dental care in the US is more expensive than any developed

country in the world. I don't even see how Europe no… is not denying any dental care because of their inability to pay and other countries help pay for dental care and we have to wise up about that issue. And frankly dental insurance is not really insurance, it is a maintenance plan that helps you just cover very few things and so even the, the benefits and, and the cost is so high because of that and I think its anywhere… also on an administrative side anywhere between 60 to 80 percent of what patients pay goes towards the expense of running a modern… a modern dental practice and that's from the administrative cost. I'm going to skip around the prescription drugs, but I want to go back on administrative about overhead because there was a lot of conversation about that. There's a substantial percentage of the insurance premiums paid by the employers and by the individual that go just to marketing and administration, another percentage for profits. Under the Obama care the portion of the premium goes to marketing, administration is constrained about 20 percent and for small insurance and 15 percent for large insurers, but basically higher spending also translates to higher out of pocket costs and premium

costs for the consumer. So, even… every health… emerges from New York State… even the New York State medical waiver creates a vastly complicated, more complicated system, you get a whole new fleet of consultants who make a good living assisting health care systems on how to cope with it and what happens is that their incomes become the providers expense and thus it becomes the patients bill at the end and so that's a huge issue as well. I think also… there's also this issue of state resource allocation going to two places, there was mention of DSRIP, Delivery System Reform Incentive Payment Program and they talked about how to address this. Eight billion dollars for restructuring of the health care system and most of that funding went primarily to hospitals which was one of the first mistakes. The second mistake was not building upon the community-based organizations that are actually positioned strategically to address those terms of health. An appointed recently in this… was those organizations but we still continue having not a real integrated approach of having community people help with dropping the cost in terms of health care and what they address in terms of non-clinical care and so as

the state embarks to the new Medicaid… is… I think it's… to assist in lowering what the US cost is by engaging more of those social and community-based organizations. Then there's the other thing that Liz mentioned, the indigent care pool, sometimes we call charity care, its been a huge inequity how to get distributed, you have certain hospitals that are getting so much money for, for indigent care and not… and not even serving, serving less than ten percent of uninsured and some of them are right across the street from each other, hospitals and so that inequity needs to change and so we, we're really pushing for the state to pass the Gottfried and Gustavo two pieces of legislation to actually change that inequity but that also translates into why we have higher cost of care too. So, I think I'm recommending a few things here is we have to capitalize on the strengths of its infrastructure while enabling change and engaging new allies to better address this issue not solely consultants, not solely the insurance industry, not solely the hospital industry. We have to support raising taxes on the ultra-wealth, wealthy, we need to look at that in order to pay for… have their fair share in this

stuff. There needs to be price transparency in health care obviously, actually easy to understand, meaningful information. So, I don't… I go against the idea that it, it's going to be hard to do that, that is a lot of BS coming from the other side of the industry. I think also the state Department of Financial Services has to be more accountable to New York City residents, New York State residents its tax to monitoring health care costs in New York, we need to look at what's going on there, what are they reporting, what are they doing there. Particularly some control around efforts controlling the health care costs for their employees but not all… not all about the expense but also around addressing access to care, what does that mean in terms of correlation. I actually think there should be a study that could be done on how many jobs health care reform proposals create or destroy and how it relates or… to rising or reducing health care costs. I think we have to address the magnitude of the administrative overhead; we need really to know what care is buying, what health care is spending is buying. While my, my testimony wasn't part of, of this surprise billing law, enforcing it, the education and awareness of

that within communities and then obviously we need a financial, stable safety net system that includes support for two bills that accomplish the equity around the charity care and I'm going to just be honest, although this is a complicated issue around… for labor union concerns addressing the New York health care act, we understand that in the fight for Medicare for all roughly half of all US health care spending is currently done through government budgets, Medicare, Medicaid, Tricare, Veterans Affair for the military and public health. Medicare is the classic single payer system and that the military, and the veterans operate under the same system where financing delivery is operated by the government. In addition, health care spending in the private sector has increased faster than even in the public sector so why would policy makers believe that public spending is unsustainable but private spending is sustainable. So, I think that New York health care has to be passed by the state legislature as one key piece around the cost and obviously around access to care. Thank you.

CHAIRPERSON LEVINE: Thank you so much Anthony, please.

NAYSHA DIAZ: Good afternoon. Hello, okay, perfect. Good afternoon, my name is Naysha Diaz and I'm a Government Relations Associate at Planned Parenthood of New York City. Thank you both Chair Levine and Chair Rivera and the Committees on Health and Hospitals for holding this hearing. Planned Parenthood of New York City provides a wide range of services and we're a trusted provider in health care because we're committed to providing comprehensive and inclusive care. In the United States health care costs have continued to rise for all parties; employers, individuals and medical providers. As a result, many people… sorry, causing many to be uninsured, as a result many people rely on safety net providers that offer financial help or sliding scale costs, community health care centers and health and hospital facilities. At PPNYC we are committed to providing care for all and offer our service on the sliding scale additionally all patients have the opportunity to meet with financial counselors who screen patients for eligibility for insurance programs. In 2018 PPNYC was able to help over 6,500 underinsured patients obtain health insurance. Federal actions also contributed to rising health

care costs, this year the Trump/Pence administration implemented a gag rule for all providers who participate in Title X family planning program. As a result, PPNYC was forced to withdraw from the program and despite, despite the fact that 50… 150,000 New York City residents relied on this program for care. This gag rule disproportionately effects immigrants with lower incomes since many aren't able… eligible for health insurance. So, while PPNYC and many other former Title X recipients will remain open it is not without cost to the health care providers. Costs for many of our patients are rolled and private insurance have also increased, nationally the amount employers and employees have paid for health care premiums and out of pocket expenses has significantly increased over the past ten years. This places a heavy burden on individuals, families and employers. In our health centers certain health services such as HPV vaccines are not covered by insurance making it… by insurance making accessing care a burden for our patient. In addition, we have noticed that patients are not signing up for qualified health plans or are unable to use their coverage because they cannot afford the deductibles. These burdensome and expensive costs

force patients to pay for care out of pocket or rely on sliding scale services if their health, health care providers can offer the service. At PPNYC we know how crucial it is for patients to be able to access health care and PPNYC applauds the City Council for its efforts to address the rising costs of health care. We appreciate the steps taken to protect health care through legislation like resolution 918 and Intro 1668. These bills support increased access to health insurance regardless of immigration status, employment status or preexisting conditions. We look forward to continuing to work with the City Council and we are hopeful that collectively we can make our city healthier and more affordable for all. Thank you.

CHAIRPERSON LEVINE: Thank you Naysha.

PATRICK KWAN: Hey, thank you first City Council and Chairs Rivera and also Chair Levine for the opportunity to testify. I'm Patrick Kwan, the Senior Director for Advocacy and Communications for the Primary Care Development Corporation. We were founded 25 years ago by the Mayor David Dinkins and a group of visionary health leaders and organizations including the Community Service Society and we… and

I'll probably take the opportunity to say that I'll thank the City Council building and staff for making it easy for me to actually testify and being someone who's actually recovering from a temporary disability, its making me a lot more cognizant of the missing people who are disabled who are unable to testify and I have to say that of all the buildings I've kind of worked in in the past week that City Council folks have been the best, had to say that part. So, we have worked and we have worked with over 400 health care sites throughout the city of New York and finance half of the FQHCs here in the city of New York in all five boroughs and actually in 50 out of 51 city council districts, we're hoping to get that very last one. Our mission is to create healthy and equitable communities by providing the capital, advocacy and research and expertise needed to build and expand primary care and I really want to emphasize that too many hard working families are just one medical bill, a hospital stay or an emergency room visit away from a financial nightmare that threatens their economic stability and we are… we know that New Yorkers are right to be worried about access to affordable housing and affordable

health care because the high cost of both health care and housing can drive people into bankruptcy, onto the streets and both health care and housing are needed for families and individuals who pursue their careers, education and their prosperity and stability and we also know that every year rising health care costs are taking a bigger bite out of the bottom line of workers and their families and have erased all of the average worker's wage increases and more. We've also seen that since 2009 average family premiums have increased 54 percent and worker's contributions have increased 71 percent all the time that while several times more quickly than wages at 26 percent and inflation at 20 percent over the last ten years. And I also would like to point out that this years New York City government poverty measure found medical expenses can pull New Yorkers into poverty. Of the elements that raise the NYC gov poverty rate the most medical expenses have the highest effect. In the absence of medical expenditures the city's poverty rate of 19 percent will be 2.9 percent lower, percentage points lower and medical expenses have pushed more than seven million Americans into poverty or in deeper poverty according to a 2018 national

study conducted by researchers from CUNY Hunter College, by Harvard Medical School and these families and individuals spent about a third or more of their income on health care and of the seven million that I just mentioned more than half which are four million people were pushed into the ranks of extreme poverty which means that their post health care income were reduced below 50 percent of the poverty line and the spent about two thirds of all their income on health care and we also see the city between the… you know the have and have nots and also in this very same study the lowest ten percent of income, the poorest ten percent of Americans spent up to 47 percent on average on health care while the top ten percent of income of Americans spent about just two percent of their income on health care and so we always want to emphasize that affordability is a critical component of access to health care. When we talk about the availability of providers or services at hospitals or whatever it may be, a… it's only relevant if a patient can also afford the cost of care and that they actually can, you know get out of the hospital, hospital rooms and emergency rooms without being driven into bankruptcy and having their financial

stability threatened. We also know that rising health care costs are coupled with rising costs of health care reform and we know the complexity of the US health care system and issues of inequality and inequity and it really seems that nothing can be done. We've talked previously about the importance of prevention, of the preventing the drug prices and preventing the out of network charges, the other coin of that prevention is making sure that we have primary care services to ensure that people can identify, treat and manage their illnesses before it gets more costly, difficult and serious to treat and it's a lot of times that there's a less apparent solution and fix to prioritizing primary care. We know that New Yorkers need hospital beds when they are seriously sick and emergency rooms for emergencies and what we believe is that most of all people need primary care services to stay healthy, maintain our health and also to avoid hospital stays and emergency room visits. We firmly believe that without primary care family risk illnesses that can threaten their wellbeing and financial security as well as worsen their health, social economic inequities. At PCDC we believe that the entire

premise of health care reform must rest on a robust high quality universally accessible primary care system. We know that primary care is not a solution to every health issue but there are very few chronic health conditions that can be managed better without primary care. We also know that in New York City communities many people leave the access to primary care that can allow them to manage the illnesses that prevent them from getting more serious and take them to the emergency rooms, ending up in hospitals and also the issue where that they have to rely on urgent care and urgent care while that they are better than emergency rooms and better than hospitals is that they are also a much higher cost of care to patients that they have to rely on those costs rather than their primary care doctors which is why that PCDC strongly supports the investment commitment made in recent years by the City Council to Health and Hospitals and DOHMH in expanding primary care and we would like to encourage the City Council to explore additional opportunities to promote primary care by maximizing the City Council grant funds for additional primary care expansion. We've financed several projects here in the city of New York by

combining City Council grant funds with New York State revolving loan fund and also federal new market tax credits and we've done that at Callen-Lorde, the… for the downtown Brooklyn expansion right here around the corner and this is extremely important for us to use resources that are limited strategically to make sure that the reach can do that and we also would like to commend the City Council for investing in the FQHCs and this is extremely important that we do that as well as supporting primary care and behavioral health integration. Many patients with serious mental illnesses are often effected by chronic medical conditions and just as important to integrate behavioral health into primary care settings we must also integrate primary care into behavioral health settings to help reduce and prevent the chronic conditions to promote wellness for all New Yorkers. Thank you for your consideration for our recommendations, thank you.

COUNCIL MEMBER RIVERA: I just… thank you and I just want to recognize that we were joined by Council Member Ayala who's a big advocate for us.

CHAIRPERSON LEVINE: Thank you Chair Rivera and thank you to this excellent panel. PCDC in

addition to the really invaluable financial and other support you offer to primary care providers, you've just be… you just provided a wealth of data in general to the City Council that again and again has been really helpful in us understanding the trends in health care so I want to thank you for that. To the panel as a whole, to what extent have… has consolidation in the hospital industry which seems to be relentless contributed to the crisis of affordability, can any of you weigh in on that? Yes.

ELISABETH BENJAMIN: There's a really important health affairs article about that that came out in the last couple of months and I really would… and it's, you know contrary to what the industry says health care consolidation has driven up prices, you know in a stunning rate and so, you know it's, it's a problem.

CHAIRPERSON LEVINE: Is, is that because there's less competition or why, why has consolidation had that effect do you know?

ELISABETH BENJAMIN: Well I mean a couple of reasons, number one, so I'm a hospital now what DSRIP in fact really encouraged was for hospitals to take over what used to be community based practices,

right, so now the community based practices get to charge the hospital base rates and the facility fees, right, so… now wait for it, like… it's just that and all of those are just sort of more and more driving the, the increase in cost in the system but it looks like Anthony wanted to weigh in so… [cross-talk]

[off mic dialogue]

ELISABETH BENJAMIN: Yeah, so I, I think… you know I mean I agree with Anthony's point which I wish I had made which is if we actually had deep and thoughtful health planning in New York State someone might have been able to say why would you give a billion dollars to the hospitals to buy small community based practices so that all of you all can charge hospital based rates which are much higher than the old primary care rates, why wouldn't we invest eight billion dollars for example in doing something that, you know Mr. Title asked about… talked about, I think several people talked about that there's not enough health care capacity, why wouldn't we build out primary care physicians, why wouldn't we build out paraprofessionals or nurse practitioners practice… you know nurses, I mean there's so many, you know levels of health care that

we could be building in a smart way that would get health care into communities that would bring down our health care costs that we just don't engage in that kind of planning in New York instead the planning appears to happen in a very, you know classic New York back room kind of way and there is no planning.

ANTHONY FELICIANO: I mean Elisabeth is right, I think there's other aspects of this, one says there's consolidation then there's some decisions about what are services that are vital and not vital in their mind once they do those consolidations so we constantly see maternity services starting to shut down, pediatric services shutting down, once you see these consolidations and mergers. Now there's also extrinsic other issues going on, most consolidation and mergers and even closings have ended up with something that the community really didn't need anymore so in, in the issue of closings almost like 50 percent of every closing of a hospital, some that's been taken over by other… another hospital and services that space that has remained vacant or… [cross-talk]

ELISABETH BENJAMIN: Or be condos…

ANTHONY FELICIANO: …or turned into condos which does not address any housing needs of those communities that are already marginalized so there is use… other issues that goes on that impact other areas when these consolidations occur and so that's a huge issue and there's been plenty of studies showing including from Alan Sager and Boston and others showing where it just have risen costs more and really has not been a saving in the consolidation.

CHAIRPERSON LEVINE: DSRIP was supposed to save… was supposed to bend the curve on cost, was it not?

[off mic dialogue]

CHAIRPERSON LEVINE: Well increase, increase value but… [cross-talk]

ELISABETH BENJAMIN: As usual I mean I don't know… [cross-talk]

CHAIRPERSON LEVINE: …it was… [cross-talk]

ANTHONY FELICIANO: I mean… [cross-talk]

ELISABETH BENJAMIN: …I mean I don't… its not clear to me that they… [cross-talk]

ANTHONY FELICIANO: We, we never were very clear on the goal, obviously reducing emergency room use will… hopefully would do that, right and… [cross-talk]

CHAIRPERSON LEVINE: Right… [cross-talk]

ANTHONY FELICIANO: …and hospitalization but in the end we don't know yet to be honest and I'm just going to remind us we keep going through this every time, more than ten years ago there was a primary care initiative, I was a part of it, LaRay Brown which was at the time at Health and Hospitals, a report that talked about the primary care expansion, it seems like we constantly go back in conversation, every Medicaid where it was around also primary care expansion has not resulted in it, the chip dip which I call it a different name and the F-sharp which I call F-flat which was another waiver all didn't reach those goals so I think there's a real issue about what are you addressing and how you're addressing it when it comes to the funding streams and so I think that's a huge issue and there's also… there's an issue for community based organizations, they think that we should consolidate and merge too just like the hospitals.

PATRICK KWAN: And I'll also talk about the fund flows we're doing, at PCDC we're doing complete fund flows of all the district funds, one of which that they did share the data for and I think it was for year four, quarter… I… which quarter where we found that about 40 percent of the money was going to hospital administration, the administration of the PPSs and less than four percent of average was going to the community based primary care providers and folks who were there.

ANTHONY FELICIANO: Sorry, the state had the audacity to tell some state hospitals to give back some of the money because they went above the five percent threshold for non-clinical contracts which is, is, is just crazy what they're thinking.

CHAIRPERSON LEVINE: And, and there's going to be a DSRIP two point oh soon, no, do we have hope that for example that would incorporate insurers, could this… [cross-talk]

ANTHONY FELICIANO: Well the, the, the problem is right now that it will… [cross-talk]

CHAIRPERSON LEVINE: No?

ANTHONY FELICIANO: …incorporate NCOs in a much bigger way and that's some of the concern that

we're having as community-based organizations because the decision-making process and where the money is distributed but the other part of… I don't bet that they make all the money so where are they going to prioritize the funding if they don't get all the funding, my understanding is if they don't get the funding at all its going to go into the, the health homes area or the HARPs and we have an issue there as well when it comes to… [cross-talk]

CHAIRPERSON LEVINE: And you're, you're quizzical look Elisabeth?

ELISABETH BENJAMIN: You know… I mean…

CHAIRPERSON LEVINE: Okay. Understood. So, the city… the state is facing a projected four-billion-dollar shortfall in, in Medicaid for the coming fiscal year, is, is that the estimate currently?

ELISABETH BENJAMIN: Yes.

CHAIRPERSON LEVINE: And can, can that be directly attributed to the cost increases that we've been talking about today? Not so simple?

ANTHONY FELICIANO: Not that simple.

[off mic dialogue]

CHAIRPERSON LEVINE: So, part, partly it's, it's, it's changes we would applaud such as moving to fairer pay, but it doesn't reflect changes in utilization rates or… [cross-talk]

ELISABETH BENJAMIN: No comment… [cross-talk]

CHAIRPERSON LEVINE: …changes in cost… [cross-talk]

ELISABETH BENJAMIN: I mean utilization in, in New York has gone down by two percent, hospital prices, I think I have it in my testimony has gone up by… I don't… 36, 40 percent, I've got somebody else's so I mean it's… there's… yeah, it's… there's a… there's some kind of disconnect happening, I mean people are terrified to go into hospitals so that… we know that's true, yeah, inpatient prices went up 32 percent versus 60… in New York versus 16 percent nationally so I'm not really… so, I'm not really sure what's going on there and in terms of, I think Mr. Title said we haven't had an increase in Medicaid reimbursement rates but I would just like to point out that in fact, you know the vast majority of health care is provided through the Medicaid managed care plans and the Medicaid managed care plans have

gotten annual rate increases every single year. So, I, I think it's around a reasonable medical trend… I mean a trend around three percent, 3.5 percent, Leslie can correct… okay, but, but… you know I think if you average it out to around three percent… so, I wouldn't say that there's been some kind of rationing that's happening, you know I… here not to mention that the, the eight billion dollars that went in to the… to our hospital system so I'm not really clear on how the math is calculated, it may be true that the fee for service Medicaid rates haven't been raised in ten years but who's left in fee for service all, all 12 of them, you know… I mean…

ANTHONY FELICIANO: I think you… there's two other pieces to this revisiting the, the global spending cap again and it really has been working, I think it needs to be obviously changes to that and the second aspect of this is any cut across the board to hospitals impacts very differently a safety net hospital versus a hospital that doesn't play as a real safety net for communities and what I mean in terms of that is in terms of serving the uninsured and, and hide populations of Medicaid so if you get a two percent across the board cut it impacts very

differently health and hospitals than to be honest with NYU.

PATRICK KWAN: And you'll also see that the cuts are effecting community based providers the most especially folks who are serving the underserved, those are the folks who are disproportionately getting the cuts and we are seeing the folks who invested in patient centered medical care and folks are doing some of that work that they were promised the incentives of doing that and making the up front investments to do that that they are being told that some of their reimbursement will have to go down and those are the ways of how the cuts are being made where it shouldn't be.

ELISABETH BENJAMIN: I mean we could try a thing called global payments and budget… you know and actually have global rate setting, I mean Massachusetts is moving towards that, I think there's a lot of wisdom in that, I mean clearly the current, you know caucusiness [sp?] system isn't working so there is a thing called rate setting, it isn't exactly single payer and maybe that would… you know we were kind of stupid I think in the Pataki administration when we shifted from our NYPHRM to the

HCRA system, you know which is deregulating our rate setting and I think it, it hasn't served the state well.

CHAIRPERSON LEVINE: Word of the day, our caucusiness system. Naysha you, you brought up a point which needs to be emphasized probably more than we have in this hearing which is the extent to which the exorbitant pricing of pharmaceutical companies has inflicted pain on patients and providers, could you tell us how it's affecting your work, what are the specific cases where this is really most detrimental to your… the patients that you're serving?

NAYSHA DIAZ: So, I'll give part of the answer, I think the… one way that I feel that patients are being impacted most is definitely Hep and Prep and Pep, I think the cost of Prep and Pep partially because of the patent and partially because of pharmaceutical companies, it's expensive for us and it's even more expensive for our patients, I can get back to you with more answers and other services that… where costs are highly impactful but I think those are two of the medications that are most burdensome to our clients.

CHAIRPERSON LEVINE: Okay, thank you. We actually we, we focused on that on a… on a hearing earlier this week and I see you also included the HPV vaccine as well as excessively priced…

NAYSHA DIAZ: We also… [cross-talk]

CHAIRPERSON LEVINE: Okay, thank, thank you to this… what, please.

NAYSHA DIAZ: Yeah, we also submitted testimony for the HIV and HEP-C prevention hearing as well so there are recommendations in that testimony.

CHAIRPERSON LEVINE: We, we definitely appreciate that and we'll review it and I want to thank this panel, all-star panel of experts for all you do to fight for patients in New York State and I want to thank everyone who testified today in this very important and productive hearing and this will be our conclusion. 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 19, 2019