CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

THE COMMITTEES ON HOSPITALS AND HEALTH

---------- X

Thursday, February 23, 2023
Start: 10:18 A. M.
Recess: 2:39 P. M.

HELD AT: Committee Room - City Hall

B E F O R E: Hon. Mercedes Narcisse, Chair
Hon. Lynn Schulman, Chair

COUNCIL MEMBERS:

Joann Ariola
Charles Barron
Selvena N. Brooks-Powers
Oswald Feliz
Jennifer Gutiérrez
Crystal Hudson
Rita C. Joseph
Francisco P. Moya
Mercedes Narcisse
Carlina Rivera
Marjorie Velázquez
Kalman Yeger

OTHER COUNCIL MEMBERS ATTENDING:
Julie Menin

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

MICHELLE MORSE, M.D, MPH,
Chief Medical Officer and Deputy Commissioner of the Center for Health Equity and Community Wellness New York City Department of Health and Mental Hygiene

CLAIRE LEVITT,
Deputy Commissioner at the Mayor's Office of Labor Relations

DANIEL POLLAK,
First Deputy Commissioner at The City of New York Office of Labor Relations

DAVID RICH,
Executive Vice President of Government Affairs, Communications, and Public Policy at The Great New York Hospital Association

CORA OPSAHL,
Director of the 32BJ Health Fund

HENRY GARRIDO,
Executive Director, DC37

PAT KANE, RN,
NYSNA Executive Director

LISA YOUNG RUBIN
Volunteer with the NYC Organization of Public Service Retirees

SUE ELLEN DODELL,
New York City Organization of Public Service Retirees

MARIANNE PIZZITOLA
President NYC Organization of Public Service Retirees & FDNY EMS Retirees

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

SUE ELLEN DODELL,
New York City Organization of Public Service Retirees

LISA YOUNG RUBIN,
Volunteer with the NYC Organization of Public Service Retirees

BARBARA CARRESS,
Health Policy Professor PSC/CUNY

NEAL FRUMKIN,
Vice President, Inter-Union Relations for DC 37 Retirees Association

AUREA MANGUAL
Retiree from DC 37 local 317 NYC, Labor Leader and Activist

KEVIN MORA,
Co-founder of Power to the Patients

LESLIE MORAN,
Senior Vice President of the New York Health Plan Association

JOSEPH TELANO,
Senior Policy Manager with Primary Care Development Corporation

Elisabeth Benjamin
Community Service Society of New York - Health Care Division Department

ILARIA SANTANGELO
Director of Research at PatientRightsAdvocate.org

MEDHA GHOSH,
Policy Coordinator at Coalition for Asian American Children and Families

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

DR. VIKAS SAINI,
President of the Lown Institute

LOLA SIMPSON,
CEO of AIRnyc

MARIA VIERA,
Vice President of Community Affairs at RiseBoro Community Partnership

DAVID SELTZ,
Executive Director of the Massachusetts Health Policy Commission (HPC)

CHRISTIN DEACON,
Healthcare Leader; Former Director of Health Benefits Operations and Policy and Planning State of New Jersey

SERGEANT AT ARMS: Good morning and welcome to the New York City Council Hearing of the Committees on Health jointly with Hospitals.

At this time, can everyone please place all electronic devices to vibrate or silent mode?

If you wish to testify today, please come up to the Sergeant's desk to fill out a Testimony Slip -- even you have already registered online.

Thank you for your cooperation, Chairs, we are ready to begin.

CHAIRPERSON NARCISSE: Good morning

[GAVELING IN] [GAVEL SOUND]

Good morning, everyone, I am Council Member Narcisse, Chair of the New York City Council Committee on Hospitals.

I want to thank the Administrative, my colleagues, and the advocates for joining us at today's hearing.

The purpose of today's hearing is to hear and receive feedback on Introduction Number 844 and Preconsidered Resolution T2023-3046, both sponsored by Council Member Menin.

As a registered nurse, I am very aware of the health care struggles that impact New Yorkers. It is

critical that we work to ensure that our diverse communities are equally aware and feel empowered and confident to make health care decisions for themselves and their families.

In conclusion, I look forward to hearing testimony from the Administration as well as the dedicated advocates.

I would also like thank Council Member Menin, and the Health and Hospital Committee's staff, as well as my team for their work on this hearing.

I will now turn it over to Chair Schulman, Chair of the Health Committee, thank you.

CHAIRPERSON SCHULMAN: Thank you, Chair Narcisse.

Good morning, I am Council Member Lynn Schulman, Chair of the New York City Council Committee on Health.

I want to thank you all for joining us at today's joint hearing with The Committee on Hospitals, chaired by my colleague Council Member Narcisse. We are also joined by Council Member Menin.

Today's hearing is on Introduction 844, sponsored by Council Member Menin: A Local Law to amend the New York city charter, in relation to establishing an Office of Healthcare Accountability.

We will also hear Preconsidered Resolution T2023-3046, also sponsored by Council Member Menin:

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

As I have said before, access to affordable and quality health care is a human right. I have dedicated my personal and professional life to health care advocacy. And in New York City, we are dedicated to providing *all* New Yorkers, no matter what their zip code is, with the necessary tools to make the most informed decisions on issues related to their health and quality of care.

I want to conclude by thanking the Administration, Council Member Menin, the unions, and the advocates for being here today, as well as the Health Committee staff, Committee Counsels,' Christopher Pepe and Sara Sucher; and Mahnoor Butt, Legislative Policy Analyst, as well as my team:

Jonathan Boucher, and Legislative Director Kevin McAleer.

I will now turn the mic over to my colleague, Council Member Menin, to give a statement on her bill.

COUNCIL MEMBER MENIN: Thank you, so much Chair Schulman and Chair Narcisse for holding today's critical hearing regarding health care accountability and transparency.

I am proud to speak about my bill Intro 844, also known as The Healthcare Accountability and Consumer Protection Act.

This Act would make New York City the first city in the country to create an Office of Health Care Accountability.

Our city is at a breaking point, with health care spending now equating to over 10 percent of our annual budget. For context, in 2000 the City spent $1.6 billion on health insurance for employees, dependents, and retirees. By 2017, that number rose to $6.3 billion, and continued to skyrocket to an estimated $11 billion in 2023.

My legislation, which is sponsored by a super majority of council members, 43 in total, can assist

the City to leverage its purchasing power to slow down spiraling health care costs.

Price transparency works. There are a myriad of examples where states were able to lower costs with transparency laws.

In 2007, New Hampshire launched the website Health Cost, to improve health care transparency. A 2019 analysis of this system's impact found that over a five-year period, the cost of medical imaging procedures decreased by 5 percent.

Likewise, the state of California saw a 20 percent reduction in joint replacement costs alone. Imagine the hundreds of millions of dollars in cost savings New York City could realize if we pass this bill.

And I do want to note that some studies have pegged that cost savings at close to $2 billion dollars.

This is a major consumer protection issue, as New Yorkers often struggle to understand the associated costs of health care services.

In New York City, a C-section can cost anywhere from $17,000 at an H+H Hospital to $55,000 at Montefiore.

And, as seen in the graphic, and we have a couple of charts here, I hope you can see them.

As seen in the graphic before you, a routine colonoscopy costs anywhere from $2,000 at one New York City hospital, to $10,000 at New York Presbyterian.

Families across New York City are already cost burdened and many have medical debt. How can we consider this a fair system when consumers are deliberately left unaware of the cost of services?

The legislation is designed to increase transparency for consumers and patients compared to what exists now. My office spent literally hours navigating existing price transparency tools on various health care network websites, and we quickly learned the intent of transparency is not being abided by.

For example, as you can see on the poster, there is an image of New York Presbyterian Website, the website is literally broken. To even get to the transparency page, it takes five different pages to get in, and then once you find it, if you type in the words "colonoscopy" or "cesarean" on the page's search engine, the result is nothing.

As you can see, also in this poster, from Maimonides, their price transparency consists of over 109,000 numerical rows, which is literally gibberish in an excel spreadsheet. I defy anyone to actually decipher the cost of service for any of those procedures.

And, finally, an example from Northwell Health - Lenox Hill Hospital, price transparency is delivered in an unreadable JSON file. Has anyone heard of a JSON file? JSON is intended, literary, I am not joking, for data researchers and not the general public. So, one can get a migraine just by trying to go on the various New York City hospital websites trying to figure out what on earth any procedure costs.

I do want to say, in closing, I am proud to talk about my Resolution, which is being heard today, calling on the State to create an independent commission overseeing hospital service pricing to increase access to services, promote financial stability in the healthcare sector, and reduce costs for all New Yorkers. In 1996, former Governor George Pataki opted to deregulate the hospital industry for "A stronger and healthier health care system," which

I want to note, The Greater New York Hospital Association opposed with President Kenneth Raske stating at the time, "This is a complete abandonment of any sense of commitment to the public good," end quote. He was right, as the entire health care industry is in dire need of transparency and regulation.

Finally, I want to say a tremendous amount of work has gone into this bill -- the drafting of the bill that we are hearing today. I want to thank drafters Sara Sucher, Nicholas Widzowski (sp?), Nell Beekman, Julia Goldsmith-Pinkham, Mahnoor Butt, Christopher Pepe, and Sara Liss. And, from my team, Jonathan Szott, Brandon Jordan, and Anna Correa. Thank you so much.

CHAIRPERSON NARCISSE: I want to say thank you Council Member Julie Menin for the work that you are doing, thank you.

And, now, I would like to acknowledge my colleagues, Council Member Barron, Council Member Ariola, and Council Member Brooks-Powers.

And, Council Member Brooks-Powers, do you have remarks?

COUNCIL MEMBER BROOKS-POWERS: Thank you, Chairs. I just wanted, uh, first I would like to apologize, I am going to have to leave for a district event early, but I did want to lend my voice and support of the legislation being heard today. Recognizing the need to have greater transparency when it comes to health care and ensuring that all New Yorkers get fair access to quality health care, and are not price marked out of that. And, so, uh, I would like to thank you for your leadership on this and for moving this bill forward. Thank you

CHAIRPERSON NARCISSE: Now, we would like to transfer it back to committee counsel to administer the oath.

COMMITTEE COUNSEL: Thank you, good morning.

Please raise your right hand.

Do you swear to tell the truth, the whole truth, and nothing but the truth, before this committee, and to respond honestly to council member questions?

[ADMINISTRATION AFFIRMS]

Thank you, you can proceed.

CHAIRPERSON NARCISSE: Thank you, now we would like to hear administration testimony.

DEPUTY COMMISSIONER MORSE: Good morning, Chairs Schulman and Narcisse, and members of the Committees on Health and on Hospitals. My name is Dr. Michelle Morse, I am the Chief Medical Officer and Deputy Commissioner for the Center for Health Equity and Community Wellness at the New York City Department of Health and Mental Hygiene. On behalf of the Commissioner, thank you for the opportunity to testify today.

The mission of the Health Department is to improve and protect the health of all New Yorkers. In my capacity as the agency's first Chief Medical Officer, my team is dedicated to working across the Health Department and in partnership with health care delivery organizations to develop and implement anti-racism policies and programs that advance health equity and accountability. We have three strategic priorities for this work, all of which are aligned with the recently passed Board of Health resolution declaring racism a public health crisis: the first is bridging public health and health care, the second, advancing the Health Department's commitment to anti-racism in public health practice and policy, and the

third, which is of particular relevance for today, building institutional accountability.

I would like to take a moment to talk about this third priority and how we conceive of institutional and, moreover, health care systems accountability. The key to this is the need for the greater transparency into the workings of our health care system and the ability to meet system-wide goals, such as anti-racism, equity, dignity, access, affordability, and quality.

The New York City Health Department does not regulate health care institutions. That responsibility is held by the State Department of Health and other State agencies. However, we do use data, public dialogue, convening, and technical assistance to ensure a more accountable and equitable health care system.

Our commitment to using data and reporting to understand our health care system's treatment of marginalized populations and communities -- as well as our health care system's role in actively un-entrenching inequities -- extends beyond the Health Department's regular surveillance work and informs our public reporting during crises. For example,

during last winter's omicron COVID-19 surge, the agency published a report on hospitalizations that identified a very troubling trend: the COVID-19 hospitalization rate was more than two times greater among Black New Yorkers compared to white New Yorkers. We subsequently published a paper that used public health data to conduct an in-depth exploration and analysis of key factors, such as working conditions and access to diagnostic services and antiviral therapies, that were driving this trend. We also found that stark racial inequities in omicron hospitalization rates were attributable to structural racism and its many manifestations, including racially segregated health care. We shared these findings in multiple forums to spur action including webinars with health systems, communications to clinical leaders across the city, social media posts, and internal COVID-19-equity planning meetings.

New York City is, unfortunately, one of the most racially segregated health care markets in the United States. This means that our safety-net hospitals and facilities, which include New York City Health + Hospitals and a handful of independent hospitals, care for a disproportionate number of the City's

Black, Indigenous, and people of color (BIPOC) populations. Racial segregation in health care is in part maintained by a racialized reimbursement system, wherein those who are enrolled in Medicaid or do not have insurance are disproportionately Black and Latino. Because Medicaid reimburses at a fraction of the rate as commercial insurance, providers -- including those who receive millions of dollars in tax exemptions from the government -- are disincentivized from accepting patients that predominantly come from Black, Indigenous, and people of color (BIPOC) communities.

For New Yorkers, racial segregation in health care may mean not being able to access care at certain medical practices because your plan chose not to have that practice in their network or because the practice chose not to accept your plan. For provider systems, racial segregation can take the form of, and be reinforced by, an inability to attract and subsequently provide services to an equitable number of patients who are BIPOC and/or from low-income households. In the Chief Medical Officer Strategic Plan, the Department highlights health care segregation as a key issue area for greater health

care system accountability and transparency. The agency is currently undertaking an approach that combines mixed-methods research, community engagement, and collaborative policy development to understand the root causes of health care segregation in New York City and take appropriate action, both at the governmental and institutional levels.

Another example of the kind of accountability work that the Health Department has engaged in is the Coalition to End Racism in Clinical Algorithms also known as CERCA. Health care providers often use algorithms, which draw upon patient data, to aid in clinical decision making -- And, just a sidenote, as a clinician myself and an Internal Medicine Doctor, who practices at Kings County, I see this all the time in my practice -- There are a number of clinical algorithms currently in use that include a patient's race as a data point in a way that normalizes or assumes racial inequities in care and outcomes. Not only do these race-based algorithms entrench what we call racial essentialism -- the belief that there are innate biological differences between racial groups -- but their use also frequently leads to delays in diagnoses, different treatment options, and worse

health outcomes among communities of color and patients of color. To address these challenges, the Coalition has convened members from twelve health systems across the city who have pledged to end the misuse of race and ethnicity in certain race-based clinical algorithms and to develop evaluation and patient engagement plans related to those algorithms in order to reduce racial inequities in care.

We envision a health care system where all New Yorkers can access and receive high-quality services in settings that respect their dignity and support their flourishing. We envision a health care system where the care that someone receives is not dictated by how much money they have and what insurance they carry, the color of their skin, the language they speak, or where they live. And we envision a health care system that does not put an undue financial burden on individuals and their communities.

However, because health care is not formally recognized as a human right in this country, advancing this vision falls to the various actors that comprise our health care system: the government regulators that hold the industry to account, the health insurers that members trust to protect them

from the high costs of care, the providers who help people make decisions that are in the best interests of their health, and financial wellbeing, and the members of our communities who organize and advocate for a more just, affordable, patient-centered, and high-quality system.

Patients should have easy access to accurate, user-friendly information about their out-of-pocket expenses before they incur those expenses. When we most need care for ourselves or our loved ones, we are oftentimes overwhelmed by urgency and price shopping is not an option, or it is the last thing that we want to think about.

We look forward to greater health care price, quality, and access transparency without placing an undue burden on individuals to shop for health care at a time of high stress. By placing the focus on system-level decisions rather than individuals, we focus on the systems-level actors who can behave in a way so that people do not have to be constantly weighing their health needs against the often-exorbitant costs of health care. Indeed, the most marginalized populations are often those that are

most price-sensitive and, when faced with high costs, they may be forced to forego care.

Monitoring of health care accountability from a systems perspective, and with an emphasis on the entities that hold power over patients, is much needed.

We look forward to working with the Council to further our commitment to health care transparency, accountability, and equity. Thank you for the opportunity to testify and I am happy to answer any questions.

CHAIRPERSON NARCISSE: Thank you.

We will continue with the testimony before we come back for questions.

Claire Levitt?

DEPUTY COMMISSIONER LEVITT: Good morning, Chair Schulman, Chair Narcisse, and Council Member Menin, and members of the Committee on Hospitals and the Committee on Health. I am Claire Levitt, Deputy Commissioner for Health Care Strategy at the Office for Labor Relations, and with me is Dan Pollak, First Deputy Commissioner at The City of New York Office of Labor Relations.

Thank you for this opportunity to discuss Introduction 844 and our support for the City Council's efforts to effectuate greater transparency in the health care system, especially as it relates to hospital pricing.

While we have some concerns -- that we'll talk about with one component of this legislation -- overall improving transparency in health care pricing is a vital issue that affects all New Yorkers and demands attention, and we thank the Council for focusing on it.

As you know, the Office of Labor Relations (OLR) is responsible for overseeing the health care benefits for New York City's 1.2 million employees, retirees, and their dependents. We work collaboratively with the Municipal Labor Committee (MLC), which represents the many unions of the municipal workforce. Our employees and retirees have what is probably the most robust premium free health coverage in the country, costing the City about $10 billion a year, which is about 10 percent of the entire New York City budget.

The ongoing efforts to address health care costs trace back to the 2014 agreement we made with the

MLC to address the issue of escalating health care costs by working together to generate cumulative healthcare savings of at least $3.4 billion over the next four fiscal years, a landmark pact that has since been updated and renewed. Since then, OLR and the MLC have been working diligently on finding ways to save money on health care expenses without impacting the quality of care. We have also worked collaboratively with our health insurance partners to identify new programs to help control the escalating costs of health care. We have reported to the City Council on many occasions about these efforts.

But, despite our efforts, hospital costs continue to escalate. The lack of available information on hospital pricing has been a significant barrier to achieving health care savings for the City.

In the past ten years, the City's hospital care costs, which represent about half of our total health care costs, have doubled. To just give you some anecdotal perspective on the costs, each year, we experience hundreds of hospital claims that each exceed a million dollars in payments, despite the significant discounts offered by our insurer.

In 2016, the New York State Health Foundation reported that the variation in pricing between New York hospitals is astounding, and more significantly, it does not necessarily reflect the quality of care. Although our insurers are prohibited from revealing details on their contracted pricing at various hospitals to the City or to any employers, we are able to glean some significant information from our own payment data. Our most expensive hospital system costs the City about 2.5 times the costs of a New York City Health + Hospitals admission, which is our public hospital system and lowest cost hospitals. City employee utilization of the most expensive hospitals -- the ones that advertise the most on television -- has increased year over year, further escalating our rapidly increasing costs while hospitals push back on contractual changes that could make pricing more competitive.

Despite federal transparency requirements, the City has access to very limited information about the actual costs and contracts between insurers and hospitals. Many contract provisions include confidentiality, anti-tiering language, and other restrictions to protect hospitals while leaving

employers and consumers with limited information. While we note that recently enacted New York State legislation, the Hospital Equity and Affordability Legislation (HEAL) Act, may help to address some this issue by barring most-favored-nation provisions and restrictions on disclosure of actual claim costs, prices or quality in certain situations, we are not sure that it goes far enough to address all of the concerns that we have. Right now, technical corrections to the HEAL Act are moving forward through the legislature, and we look forward to seeing what happens with that.

So, while hospital regulation is a State and Federal government responsibility, the City could support employers and consumers by collecting available public information and disseminating it in a more easily digestible way and by working with the State to promote access to information about price and quality. In establishing any new office, we would have to be mindful of the limitations on its authority, and the cost of creating a new office and the staffing it would require. We look forward to working with the Council on those details as this legislation moves forward.

Despite our unequivocal support for hospital transparency, the City cannot support one aspect of this bill, which is the Office of Healthcare Accountability's oversight and audit rights of the City's health care costs for City employees, City retirees, and dependents. OLR and the Municipal Labor Committee work effectively together in collective bargaining where we set spending levels, we design benefits, and we select vendors for health care -- and we manage this process with a great deal of scrutiny. We already audit our major insurers -- Empire Blue Cross, Emblem Health, and Express Scripts, and we continuously audit a selection of hospital claims every month through the New York County Health Services Review Organization (NYCHSRO). It targets claims that should either have been denied for lack of medical necessity, or for payment purposes, were coded at a lower-case severity than it was. We recover money in all those audits. So, we do think that we are -- with the limited amount of information that we get, we are able to accomplish a lot in those audits.

The management framework that was established by the 2014 Health Savings Agreements helps to address

the collective bargaining issues that are inherent to addressing efficiency and costs in the delivery of health benefits to City employees, retirees and their dependents. Creation of a new entity to audit OLR and the MLC in various aspects of providing health benefits could set back those efforts considerably.

In response to the increasing hospital costs and the variation in hospital pricing, we also currently have a procurement for a new health plan in process that is exploring approaches that will encourage greater utilization at hospitals with more reasonable pricing. This is in the early stages of development but demonstrates the willingness of the City and the Municipal Labor Committee to tackle the issues of hospital costs.

We welcome your questions and thank you again for involving us in this important effort.

CHAIRPERSON NARCISSE: Thank you.

Now, we have been joined by Council Member Brewer and Council Member Joseph.

This is a tough... This is tough, because... And, I have to make it clear that we are not here to regulate. We are just looking for transparency in the best way we can to make sure that we get the best

quality healthcare in New York City. And that is the reason why we are here today.

I am very concerned about safety net hospitals that serve our community and other Black and Brown communities. I have no hospital in my district or public health care facility.

The financial stability of safety net hospitals and their ability to provide quality care and safe staffing conditions are top of mind for me.

I live close by two safety net hospitals. How can this bill help them? Anyone can answer that question.

DEPUTY COMMISSIONER MORSE: Thank you for the question Chair Narcisse. I think it is really important question to understand how price versus cost within hospitals happens, how the polices that drive that differences, and then how those recourses support the bottom line for all hospitals especially safety net hospitals. I don't have a great answer today for you for how this bill may or may not support the resourcing of safety net hospitals, but we can certainly look into it more closely at The Health Department and get back to you. I'm not sure of my colleagues at OLR might want to add anything to that.

CHAIRPERSON NARCISSE: That one... We I am very interested in that. Okay?

Which hospitals, if you know, which hospitals serve the most Medicaid, Medicare, and uninsured New Yorkers? How can we get more data on this to shed light on the financial disparities?

DEPUTY COMMISSIONER LEVITT: We don't actually have that information... (CROSS-TALK)

CHAIRPERSON NARCISSE: Mm-hmm

DEPUTY COMMISSIONER LEVITT: My guess would... My guess would be that Montefiore probably serves the largest number Medicaid and Medicare patients. But, I don't have that information right now. Our focus is on our employees who have extraordinary health insurance coverage and covered at the same reimbursement, no matter what hospital they go to. Which actually probability encourages them to use the more expensive hospitals -- without even really knowing that they are the more expensive hospitals. But, I think people are affected by the advertising that they see and by probably avoid the safety net hospitals.

DEPUTY COMMISSIONER MORSE: Just one more piece to that as well, is that we also know that half of all

Medicaid beneficiaries in the state of New York are here in New York City. So, we do have a very large proportion of the state's Medicaid beneficiaries.

CHAIRPERSON NARCISSE: What are the different types of community benefits does a hospital provide as required to received federal tax exemptions?

DEPUTY COMMISSIONER MORSE: Chair Narcisse, can you restate the question, please?

CHAIRPERSON NARCISSE: What other types of the community benefit does a hospital provide as required to receive federal tax exemptions?

DEPUTY COMMISSIONER MORSE: We can certainly follow up with something more in depth. We didn't prepare any specifics on that today. However, The Health Department does support and work with many hospitals across the City on their community health needs assessments. In fact, most of those systems use the data from The Health Department to inform their community health needs assessments and the plans that they develop to meet needs of communities. And as you stated, Chair Narcisse, that is a federal requirement, that they report on that as a part of their tax exemption process. But, we can follow up

with additional details after the hearing if you have other specific questions for us.

CHAIRPERSON NARCISSE: I want to make sure we are centering the most marginalized and making good policies. That's the reason that we are here today. I understand it's difficult. Some folks say, no, we should not even touch it, because it is a federal... Yes, we understand that part. But, we are looking for transparency. That's why I am asking those questions.

DEPUTY COMMISSIONER LEVITT: We are not suggesting in any way that we should not be touching it. [INAUDIBLE]... (CROSS-TALK)

CHAIRPERSON NARCISSE: No, no, I'm saying not you personally... (CROSS-TALK)

DEPUTY COMMISSIONER LEVITT: We are fully supportive of the idea of transparency. Transparency is the first step to any of the initiatives that we want to talk about in terms of monitoring and effectuating health care savings.

CHAIRPERSON NARCISSE: So, uh, like I was saying, I want to make sure we are centering the most marginalized and making good policies.

How does denial of medically necessary care by insurance companies impact costs to the patients in a hospital?

Do you want me to repeat it?

DEPUTY COMMISSIONER LEVITT: Yes, please.

CHAIRPERSON NARCISSE: Okay.

Since I want to make sure that we are centering the most marginalized and making good polices, how does the denial of medically necessary care by insurance companies impact costs to the patient in the hospital... (CROSS-TALK)

DEPUTY COMMISSIONER LEVITT: The denial of medically necessary care?

CHAIRPERSON NARCISSE: Yes.

DEPUTY COMMISSIONER LEVITT: There is some limited denial of medically necessary care that we see in the employee population, but it is not denial.. It’s not so much denial of care as is it moving care to more appropriate venues.

So, for example, I noticed there is a lot of discussion, uh, there about colonoscopy outpatient costs. Colonoscopies routinely should not even be done in a hospital. They should be done in ambulatory surgery facilities or doctors’ offices,

unless a patient has extraordinary needs and needs to be in the hospital. That's the kind of so-called denial we see in terms of medically necessary care. That a recommendation will be made, this procedure doesn't need to be done in hospital; it needs to be done in an ambulatory surgery facility where you're going to get equal if not greater reimbursement for it.

CHAIRPERSON NARCISSE: But, one of the things that I have heard from many, is that the reimbursement for hospital is greater than the outpatient, and that is the reason that most of the patients end up in the ER in some ways.

DEPUTY COMMISSIONER LEVITT: That the re... That reimbursement in the hospital? Actually, the reimbursement... Our reimbursement for both hospital and hospital outpatient, uh, is really almost equivalent. We have a $300 co-pay for hospital inpatient stay. We have for an outpatient we have a $200 maximum co-pay. So, we are really not incentivizing people to go to the hospitals. You know, the employee situation really is very different than what we are talking about with a lot of our marginalized groups, because we have great coverage.

And ,you know, and it is a very different situation when people are making choices between all of the hospitals without the need to look at what the costs are, because the costs for them are the same.

CHAIRPERSON NARCISSE: In Introduction 844, that is what we are talking about most of today. What is your position on Introduction 844, which would establish an Office of Health Care Accountability -- you already know that -- to audit City expenditures on employees' related health care costs and make recommendations on how to lower this cost, right?

FIRST DEPUTY COMMISSIONER POLLAK: Thank you, Chair Narcisse.

So ,you know, we are broadly supportive of the effort to establish greater health care transparency. You know, our one concern with the legislation is the aspect about auditing City employee health costs and having this office involved in that effort. You know , we negotiate City employee health talks with the Municipal Labor Committee, we work with them, we do our own audits. And ,you know, we really feel that that is a matter that is best left for that process between OLR and the Municipal Labor Committee. But, overall, we are greatly supportive of the effort to

improve price transparency, and we look forward to working with the Council more on the details of that.

DEPUTY COMMISSIONER LEVITT: We also think that it can help inform our work. All of this information on transparency will very much help inform what we are negotiating with the Municipal Labor Committee, what we are negotiating with hospitals. We are to some extent, despite the fact that we have access to a great deal of information, we are still somewhat in the blind about hospital pricing and insurer pricing. And we hear from both the hospitals and the insurers that the information is confidential. And, while we have our own data, we don't know all of the things that drive that data.

CHAIRPERSON NARCISSE: I am going to ask that to the doctor again. What are the primary factors that contribute to health care costs -- in your opinion as a practitioner?

DEPUTY COMMISSIONER MORSE: Thanks, Chair Narcisse. And just to follow up on my colleagues at OLR, The Health Department is also supportive of the intent of this bill, and we believe that transparency about hospital prices and other health care prices as well, is critical to advance equity and improve

access. And we also believe that, as our colleagues at OLR, that making that data much more legible for the public is certainly consistent with those values around transparency.

From my clinical experience, as a physician and as a member of The Health Department or a staff member at The Health Department, certainly a big part of the challenge with costs in health care is that we invest more in treatment than in prevention. And from The Health Department perspective, certainly investing more in prevention activities and services would both improve the health New York City overall; it would improve population health equity, and it will certainly reduce some of the health care costs that we see growing. I will leave it at that. Thank you for the question.

CHAIRPERSON NARCISSE: So, you're the only physician there, right?

What health outcomes has your community experienced as a result of the increase in health care costs? And have you received any feedback from the community? That's still you. You're the physician.

DEPUTY COMMISSIONER MORSE: Just to clarify, the question is what feedback have we gotten from community members about their concerns about the costs of health care?

CHAIRPERSON NARCISSE: Mm-hmm

DEPUTY COMMISSIONER MORSE: We can certainly follow up with more details on that. I will say that particularly in the era COVID, what we have heard a lot is that free vaccines and free treatment for example, have been tremendous in terms of access to care. To my knowledge, we have not done any specific surveys recently about changes in cost since COVID, but we can follow up with you about our community health survey data, which does ask several questions about the costs of health care and how health care costs might be barriers to access to treatment. I wasn't prepared with that information from that survey today. But, we can send that to you in followup.

CHAIRPERSON NARCISSE: In other words, you have that survey?

DEPUTY COMMISSIONER MORSE: Correct.

CHAIRPERSON NARCISSE: Okay, thank you.

I am going to pass it on to my colleagues.

We have also been joined by Council Member Yeger and Council Member Moya is online.

So, I am passing it on to my colleagues.

CHAIRPERSON SCHULMAN: Thank you very much, Chair Narcisse.

So, the first question I want to ask is to Dr. Morse. My understanding is that the federal government requires some information related to health care costs for patients. Can you speak to H+H's... I know you are DOHMH... to H+H's discloser of that required information? And is that anything that is shared with DOHMH?

DEPUTY COMMISSIONER MORSE: Thank you for the question, Chair Schulman.

I cannot comment on H+H's behalf on this question. But, I am sure that they could respond in followup to the hearing about how they are meeting the transparency requirements at the federal level.

CHAIRPERSON SCHULMAN: You had mentioned earlier about the community health assessments that you have. So, does DOHMH audit those to see who is complying and who's not?

DEPUTY COMMISSIONER MORSE: The Health Department is involved in the community health needs assessment

process. In terms of a formal audit process, I don't have that information with me today, but we can certainly follow up with you.

CHAIRPERSON SCHULMAN: Because I think that if we are auditing them to see what they give back to the community, which they are required to do, I think that would be helpful to this effort... (CROSS-TALK)

DEPUTY COMMISSIONER MORSE: The State does do that.

CHAIRPERSON SCHULMAN: Okay.

How much total... So, this is for OLR, how much in total did health benefits for City employees and retirees cost last year?

DEPUTY COMMISSIONER LEVITT: Over $10 billion.

CHAIRPERSON SCHULMAN: How much has it grown in the last five to ten years?

DEPUTY COMMISSIONER LEVITT: Uh, it has... Let's see... It has, uh, I know on the hospital rates it has doubled in the past ten years. I'm not sure if I have the, uh, the combined rates. We can get that... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Okay, it's grown substantially, let's... (CROSS-TALK)

DEPUTY COMMISSIONER LEVITT: It has grown substantially... (CROSS-TALK)

FIRST DEPUTY COMMISSIONER POLLAK: [INAUDIBLE]...

DEPUTY COMMISSIONER LEVITT: We know that the hospital costs have doubled, and everything is much higher including medical and prescription drugs.

CHAIRPERSON SCHULMAN: From your perspective, what is driving those increases?

DEPUTY COMMISSIONER LEVITT: Hospital is a very big driver of it. Prescription drugs are another big driver. Uh, we are... Once of the things we are focusing on now is our utilization at the highest cost hospitals and a growing utilization at the highest cost hospitals.

CHAIRPERSON SCHULMAN: It is estimated that two... There is $2 billion in savings available if the City's health plan were to pay hospitals the same rate as Medicare. How are you going to realize those savings?

DEPUTY COMMISSIONER LEVITT: I think it... I think that it is aspirational to think that we could get Medicare rates for commercial health insurance. We spend about $5 billion of the $10 billion on hospital costs. So, saving $2 billion would be

saving 40 percent of our overall hospital costs. It is certainly aspirational, but the first step to that is absolutely transparent and knowing what we're paying and what we are paying where.

I think it will take us awhile to get to that $2 billion in savings. Maybe some fundamental changes in the way that we reimburse health care. But, we think transparency is the place to begins.

CHAIRPERSON SCHULMAN: Do you... I know this bill covers this, which is great, but what I am going to ask you is does the City now assess the price variant among hospitals that it's members use.

DEPUTY COMMISSIONER LEVITT: We do, uh, we don't have access to the actual ,you know, other than what you see on the websites, we don't know what the insurers are actually charged by the various hospitals? But, what we are able to do is collect all of our own claims' data, so that we know what we are paying on average at each hospital for our employees and their dependents and retirees.

CHAIRPERSON SCHULMAN: So, how does the City leverage its buying power? Because, obviously we have a lot of employees, a lot of City workers, a lot

of retirees, so how does the City leverage that with the hospitals?

DEPUTY COMMISSIONER LEVITT: These are great questions, thank you, thank you, Chair Schulman.

We have leveraged it to get the best deals that we can from our insurers. We have tried to leverage with individual hospitals. Last year we had... We reached out to ever hospital system in the City -- other than H+H, which obviously we have a good relationship with. We reached out to every hospital system, jointly with the Municipal Labor Committee, and asked them to do better on the pricing for the City employees. Two of the large hospital systems refused to meet with us. The other three met with us, and said if you send us more patients, we will give you better pricing. Uh, that was... Despite leverage we have of covering ,you know, probably ten to 15 percent of the City's population, we ran into an unwillingness on the part of the hospitals to negotiate. We think through our insurers that we are getting the best rates that we can now. But, what we are looking at, uh, we are looking at a procurement right now in which we hope to leverage more of our... more of the size of our population and the influence

of our population, but also help to direct people to what we think are the lower cost, but still quality hospitals. And we are currently in the midst of that procurement.

CHAIRPERSON SCHULMAN: So, I am going to mention of a piece of possible leverage that a lot of people don't know about. So, Health + Hospitals has affiliation agreements with a lot of these private hospitals. And what that means is that their residents and interns can work and get experience in the City hospitals and then they go back to the private hospitals. They get paid a substantial, hundreds of millions of dollars to do that. And maybe that is a way to leverage some this with them. So, I wanted to just put that out there. I know H+H is not here to answer that.

DEPUTY COMMISSIONER LEVITT: No, it is an interesting content.

CHAIRPERSON SCHULMAN: What is the City's long term strategy for addressing hospital prices and the root cause of ballooning health care costs?

DEPUTY COMMISSIONER LEVITT: Well, what we are trying to do short term, which has been our long term strategy for many, many years now, is look at how we

can help direct people using preferred or non-preferred hospitals incentives. We are asking each of the insurers that are bidding on our new health plan to help us design programs that can help reduce hospital costs and overall health care costs.

CHAIRPERSON SCHULMAN: So, is it safe to say that there are a number of City offices and employees responsible for analyzing hospital and health care prices paid, which is what this Office of Accountability would address?

DEPUTY COMMISSIONER LEVITT: We work a team of people of OLR, which includes people from OMB as well as OLR, and we have consultants -- our actuarial consultants from Milliman that lead this, they're the ones that collect the data and help us analyze the data that we have.

So, we do have a great deal of information about where our employees are going and what it is costing us, but again it is aggregate data. You know, it is average data from our healthcare claims.

FIRST DEPUTY COMMISSIONER POLLAK: And I would also add that Municipal Labor Committee also has staff devoted to this effort as well as their own actuarial consultants who work with ours.

CHAIRPERSON SCHULMAN: Does the City have a process to determine the average price per procedure at major hospital systems?

DEPUTY COMMISSIONER LEVITT: We do. We do have that information.

CHAIRPERSON SCHULMAN: And how is that utilized?

DEPUTY COMMISSIONER LEVITT: Well, at this point we have not been able to... We have not been able to really actualize anything actionable from that data. We are hoping to do that in conjunction with this new procurement that we are doing.

CHAIRPERSON SCHULMAN: Okay, I am not going to turn it over to Council Member Menin for questions.

COUNCIL MEMBER MENIN: Thank you so much, Chair Schulman.

First of all, I really want to thank you for your testimony today on my bill, because I appreciate the administration's support of price transparency in the bill. And I am confident based on all of the research we have done and looking at what other states have done, that we will, once and for all, lower prices through this transparency measure.

So, one of the things you mentioned in response to Council Member Schulman that I found really

shocking is that two hospitals would not meet with the City. And as you point out, the City is ten to 15 percent of the City's population actually in these hospital systems.

So, the hospitals literally have the City over a barrel. And it is unconscionable that they are not meeting with you. And that is, again, why this bill is so important, because it will finally allow the City to harness its purchasing power to demand that these hospitals lower their prices.

So, I have a couple of questions. Last month, you told the Council at the Committee of Civil Service and Labor, that you had issued an RFP. Could you talk a little bit about that? What's the status of that?

DEPUTY COMMISSIONER LEVITT: Yes, Thank you, Council Member Menin.

We have issued the RFP. We have received some initial bids. And we have gone out to all of the bidders with additional questions, uh, based on the initial proposals that they have made. We are trying to get more detailed information than we got in the first round of information. So, we are really sort of right in the middle of the process of this. We

hope that the process could conclude some time by the end of March - mid April something along those lines.

COUNCIL MEMBER MENIN: And currently right now, how many employees across OLR and other City divisions do you have that are working on health care costs?

DEPUTY COMMISSIONER LEVITT: We probably [TIMER CHIMES] have between OLR and OMB we probably have a dozen people or so that are working on various aspects of health care costs. But, we also have our consultants at Millman where they have ,you know, a very robust team of actuaries and other research analyst that do a lot of the data analysis.

COUNCIL MEMBER MENIN: Okay, and I see my time is up, if I can just ask one last question.

If this legislation is enacted, how will that allow you to drive costs down?

DEPUTY COMMISSIONER LEVITT: Well, as I said before, Council Member Menin, I think that transparency is the first step to being able to negotiate better health care pricing. We don't know what we don't know. And this will definitely help inform us about what the costs are at the various hospitals.

COUNCIL MEMBER MENIN: Great, thank you.

CHAIRPERSON NARCISSE: Thank you.

I want to... Yes, my Council Member Charles Barron for questions.

COUNCIL MEMBER BARRON: Thank you very much. This is an incredible hearing. I've been at this for a long time, and I just find it just... First of all, this is a no brainer. I don't see how anyone can be against this bill. But, for you to have a better relationship with the greedy insurance companies then you do the hospitals... And for workers, when they come to negotiate their wages, they use... health care is manipulated so that they have to now say, okay, "Well, if we give you this raise, then you can't get this health care." Or, "If you get this health care, then the raise has to be lower." That's a game they've been playing for a long time. And it's time that we just tell the truth of what is going on with health care. You know, I know some of you may have problems with socialism, but capitalism is going mad. And in then health care industry is a real indication of that. You know, how do you have on the federal level, we have some of our members of the New York Congressional Committee or

representatives voting with republicans to condemn socialism. And in that same bill, they say we also are against socialist types of programs like Medicare and Social Security.

So, they voted against socialism in a bill that also was against Medicare and Social Security. To me that's incredible. I want to see where you stand on that.

Also, when I look at the state budget... I was in the state assembly when Andrew Cuomo was governor. He didn't cut Medicaid, he had savings. That's the new word for cuts. [TIMER CHIMES] So, any time... Please let me finish...

CHAIRPERSON NARCISSE: Sure.

COUNCIL MEMBER BARRON: Any time that you hear the word savings, they're cutting. They're cutting at a time where we have surplus in budgets.

And, then on the City level, your mayor is cutting your agencies three percent across the board. How do you feel about that. That we're talking about better service, and in a state that has a $224 billion budget, and a city that has a $1.27 billion budget, and you're cutting social services including health care.

So, when you come, show us the money. Show us the money. The rhetoric, we're tired of it. Of course, we are going to support this bill, it's going to go through. You needed to transparency to find out after all of these years that the over costs and hospitals... So, you needed transparency? Like, oh, we need to find out what's going on in hospitals. You need that now after all of these years? You didn't know the price gouging that was happening in the hospitals? So, we have to have a bill for transparency and celebrate that? And you are sitting there, like, can't wait until the bill comes out, so we can find out what's going on. Come on, ya'll need to stop it. We need to stop it and deal with our people in a real way. We are dying. We are dying in our communities. People have gone bankrupt trying to deal with health costs. And the cost goes up, but the quality of care doesn't. And that's a problem.

So, I want you to address some of that. Not this typical stuff we have at hearings. And then you say, "Oh, I don't have that. I have to get back to you." Then when did you find out you were having this hearing? For you to have to get back to us on so

much stuff, when you knew about this hearing for a while, it's a problem. It is a real problem.

So, let's cut the nonsense. Let's cut to the chase, and tell the people what's really going on -- profit over people. Health care is a multibillion dollar profit. The insurance companies are laughing their way to the bank. And we're sitting here talking about transparency. And you have a better relationship with the bankers, the profiteers, than you even have with the hospitals. That's a real problem.

So, if you can address some of that like your colleagues in the federal government supporting a Resolution that is challenging and making cuts to health care -- your mayor, who's cutting some money from your agencies, how do you really address that?

FIRST DEPUTY COMMISSIONER POLLAK: So, I'll just start, uh, Council Member, thank you.

Just to speak to ORL's role, the Office of Labor Relations, which is on City employee health costs, you know, we are not looking to make cuts to health insurance. We work with the Municipal Labor Committee, with the unions every day to try to find ways to find savings, yes. To do so while retaining

the same high quality that we want to deliver. That's been our goal... (CROSS-TALK)

COUNCIL MEMBER BARRON: I have to go. But, that's a bunch of rhetoric. There are cuts. I look at the budget. There are cuts. So, don't come here saying that you are not trying to... you're trying to find savings. Savings are cuts. Savings are cuts. So, tell the truth. And you said that you are not supportive a part of the bill, when it comes to the negotiations with Labor. Labor's supportive of the bill, but you're not. So, I'm not sure if everything is so rosy with your relationship with Labor. But, let's just tell the truth. Savings are cuts.

FIRST DEPUTY COMMISSIONER POLLAK: Definitely, Council Member , I don't agree that in all cases that that's true.

COUNCIL MEMBER BARRON: Savings are cuts.

CHAIRPERSON NARCISSE: Thank you, Council Member.

COUNCIL MEMBER BARRON: Yes, thank you.

CHAIRPERSON NARCISSE: And, now we have questions from Council Member Ariola.

COUNCIL MEMBER ARIOLA: Thank you, Chairs, I appreciate it.

My questions are for OLR. Ms. Levitt, you are in your testimony, in you second paragraph, you said that "while you have some concerns about the legislation" what is your main about the legislation?

DEPUTY COMMISSIONER LEVITT: Thank you for the question, Council Member.

The main concern that we talked about is simply whether there will be oversight from this Office of Health Care Accountability over what is now done in collaboration and in collective bargaining between the unions and the City. We don't think that that is appropriate. We do audit right now. We audit our insurers. We audit hospital claims. And we set benefit design and vendor relationships working with the unions. So, I do believe that that would sort of usurp the role that we have. We have no problem with the idea of ,you know, sharing some of the information that we have with this Office of Health Care Accountability. And we want to work with you towards transparency. That was the only aspect of the bill that we had any problem with.

COUNCIL MEMBER ARIOLA: Okay, and I also did hear you say, and it's not part of your testimony, but you did say that you were concerned about the scope of

the commission and what they would have input over and what their range of input would be. Because that is a concern of mine as well.

DEPUTY COMMISSIONER LEVITT: I'm sorry, I'm not sure... (CROSS-TALK)

COUNCIL MEMBER ARIOLA: That the commission... The commission of [INAUDIBLE]... (CROSS-TALK)

DEPUTY COMMISSIONER LEVITT: Office of Health Care Accountability and... (CROSS-TALK)

COUNCIL MEMBER ARIOLA: Yes.

DEPUTY COMMISSIONER LEVITT: what they would have oversight over?

COUNCIL MEMBER ARIOLA: Right.

DEPUTY COMMISSIONER LEVITT: [TIMER CHIMES] Only as it pertains to ,you know, what gets collectively bargained and what we work on... (CROSS-TALK)

COUNCIL MEMBER ARIOLA: Right.

DEPUTY COMMISSIONER LEVITT: with the Municipal Labor Committee. That's our only concern that [INAUDIBLE]... (CROSS-TALK)

COUNCIL MEMBER ARIOLA: Right, for our active employees and our retirees.

DEPUTY COMMISSIONER LEVITT: That's right.

COUNCIL MEMBER ARIOLA: Correct.

So, just in closing, it seems... And, you really do identify it in your testimony that there is The HEAL Act, and there were improvements to The Heal Act. There is collective bargaining that goes on already. And coming from a background of working for a safety net hospital that gives, to this day, high quality health care at a low cost, I know how difficult it can be, but it does get done. And what I worry about mostly is, if we are... If savings are cuts, than why are we layering another commission on top, which will need funding, which will need employees, and we will need people to collect the data that is already being collected.

So, thank you so much for your testimony.

DEPUTY COMMISSIONER LEVITT: You know, our philosophy has always been that savings are not necessarily cuts... (CROSS-TALK)

COUNCIL MEMBER ARIOLA: I am saying, let’s say that that’s correct. Let’s say it’s correct. Why are we creating more commissions to do what’s already being done, on a state level, and through collective bargaining? That’s my point. I’m not saying that savings are cuts. I am saying, if that is correct. This is already being done, and everybody wants price

transparency. No one could say no to that. Everybody wants good health care at low cost. But, I think that there are measures in place already that wouldn't need a new commission to be put forth, because of the concerns that you mentioned and the concerns that I have for its scope. The scope of that commission is not identified.

DEPUTY COMMISSIONER LEVITT: The concerns that we have are related only to the employee programs that OLR administers. I think that the... This Office of Health Care Accountability will address the issues on a citywide basis, where the problems, many of the problems that Dr. Morse talked about, about the inequities, are much more pronounced where people don't have access to the kinds of excellent health care coverage that our employees have. So, that I do think that transparency and empowering consumers and other employers within information is an important project.

COUNCIL MEMBER ARIOLA: Thank you.

CHAIRPERSON NARCISSE: Thank you.

We have been joined by Council Member Velázquez online, and Council Member Feliz is here with us.

Are cost negotiation processing identical among all health insurance companies? By any chance can anyone answer that question for me?

DEPUTY COMMISSIONER LEVITT: I'm sorry?

CHAIRPERSON NARCISSE: Are cost negotiations... (CROSS-TALK)

DEPUTY COMMISSIONER LEVITT: Oh...

CHAIRPERSON NARCISSE: On processes identical among all health insurance companies?

DEPUTY COMMISSIONER LEVITT: That's a great question, thank you, Chair Narcisse.

We don't have... We don't know. And that is part of what I am... It is part of what I am saying that we don't know what we don't know.

I think that different insurance companies have different approaches to negotiations with hospitals. They all have their different focuses, and the rates vary from insurer to insurer.

CHAIRPERSON NARCISSE: Mm-hmm!

DEPUTY COMMISSIONER LEVITT: a great deal. It is not just variation hospital to hospital, but insurer to insurer -- and then procedure by procedure. And, so ,you know, my sense is that when one insurer negotiates a great rate for some procedure they pay

for it on some other procedure where they're paying too much.

So, there is no consistency, and, again, we don't know what we don't know. And transparency will help us find out about that.

CHAIRPERSON NARCISSE: From my understanding, there is a wide difference in reimbursement through insurance companies. Which I think is outrageous.

DEPUTY COMMISSIONER LEVITT: That's right.

CHAIRPERSON NARCISSE: But, that is another conversation -- but, well, it should be part of this conversation. Because we do want to know.

How often do prices change on procedures at hospitals? What drives the changes in price?

And, next, do costs for patients ever decrease?

DEPUTY COMMISSIONER LEVITT: What drives it? What drives the changes is negotiations between the hospitals and the insurers. We don't always know about it. We have over the past few years gotten more information from our insurers than we ever have before. And we gotten in the middle of some of the negotiations between the hospitals and the providers and our insurers, but they drive the pricing and we don't.

And, you know, again, uh, there may be cost increases that are happening that we don't even know about until we see an uptick in our data.

CHAIRPERSON NARCISSE: And do costs ever decrease for patients?

DEPUTY COMMISSIONER LEVITT: I think occasionally there are procedures that become routine and cost and go down. But, in general, prices keep rising and rising year over year. I think that, our employees, again, have really excellent benefits, so that their costs really haven't gone up. But, I think that they are protected from the reality of the differences between different hospital systems.

CHAIRPERSON NARCISSE: All right, so, now, Chair Schulman, any questions?

CHAIRPERSON SCHULMAN: No.

CHAIRPERSON NARCISSE: Thank you for being here. Thank you for your time.

DEPUTY COMMISSIONER LEVITT: You are very welcome. Happy to be here supporting this.

FIRST DEPUTY COMMISSIONER POLLAK: Thank you.

CHAIRPERSON NARCISSE: If Admin can stay for a little longer, because we are going to have public testimony, that would be nice. If they have someone

stay here to listen to the public testimony -- if possible? Okay, thank you, we appreciate it.

COMMITTEE COUNSEL: All right, thank you.

We are now going to be moving on to public testimony. In general, we will be hearing from folks in the room first, uh, followed by folks who are logged in -- our virtual panelists.

And just a note before we call the first panel, that if you are submitting written testimony you can do so up to 72 hours after the close of this hearing. And you can submit testimony at: council.nyc.gov/testify

We are first going to hear from David Rich.

DAVID RICH: Good morning, can you hear me? Great.

Good morning, thank you so much for having me. My name is David Rich and I am with The Greater New York Hospital Association(GNYHA). Our members include all New York City hospitals, both public and private.

I hope today to clear up some serious misconceptions about hospitals, and I will explain why we believe Intro 844 oversteps the City's jurisdiction by reinterpreting Federal regulations

and then judging hospitals according to its own interpretation of Federal rules.

There has been heat than light surrounding this bill, and the rhetoric has been unfortunate. As you, know hospital saves lives 24/7, 365 days a year. They are huge economic engines for New York City. They are trusted and deemed essential by your constituents who rate them very highly in public opinion polls. Accusations of greedy hospitals, making enormous profits are unwarranted and couldn't be further from the truth.

Two highly respected national firms that found that 2022 was the worst financial year for hospitals since the start of the COVID-19 pandemic. And that over the last three years, not-for-profit hospitals have endured multiple disruptions, first, from the coronavirus pandemic, and now by labor shortages.

Labor costs are exploding due to shortages and the need to increase salaries to retain workers. In my written testimony, I detailed the enormous new costs associated with recent nursing union settlements. Many of you supported the workers and their demands for higher wages -- which is totally understandable. However, the bill for these

settlements will now come due. We would strongly support city council members providing grants to already financially distressed hospitals to help them to afford the settlements that you supported.

The rhetoric surrounding the bill also ignores the reality of hospital finances, concentrating on rates negotiated between insurers and hospitals alone, does not tell the whole story.

If you will bear with me for a moment, because this gets a little bit complicated:

More than 75% of hospital payments in New York City -- 75% are set by the by federal and state governments through Medicare and Medicaid – they are not "charged" by the hospitals -- they're set by the government. And hospitals, lose money on every Medicare and Medicaid patient, because of these government set rates. Medicare covers only 85% of the cost, and Medicaid is even worse covering only 61%. No enterprise can survive with such under payment for their services unless they can negotiate higher payments either from private insurers or they are stabilized by the state.

This is why we have 12 not-for-profit hospitals in the City need to be subsidized by the state, just

to keep their lights on precisely, because their Medicaid and Medicare share of patients is higher than the City average. These hospitals have too few privately insured patients to be able to negotiate higher reimbursement rates with to offset their Medicaid and Medicare losses. And some of these hospitals are in the districts or near the districts that you represent.

Likewise, New York City Health + Hospitals, the system with the highest proportion of Medicaid eligible patients, needs extra support that is uniquely available to public hospitals through intergovernmental transfers and City subsidies.

Other hospitals, with higher proportion of privately insured patients, can try to make up for losses for Medicaid and Medicare by negotiating higher reimbursement rates with insurers.

It is important to note that these rates are negotiated and agreed-upon by insurance companies. Rates are not a one-way street somehow dictated by the hospitals -- and a huge national for profit insurance companies have the leverage in New York City's competitive hospital marketplace, were eight hospital systems and many freestanding hospitals,

compete vigorously for patients. That is why there are price variations among hospitals -- each price is negotiated separately between hospitals and insurers.

While these hospitals have a higher proportion of commercially insured patients than the state subsidized hospitals do, they, nevertheless, provide care to tens of thousands of Medicaid eligible patients annually -- some of the biggest providers of inpatient care of the Medicaid eligible patients in the entire state. They therefor suffer huge losses that must be made up somewhere.

Proponents of the bill have claimed that if New York City paid hospitals [TIMER CHIMES] what Medicare pays hospitals, the City would save $2 billion. I don't know the veracity of this statement; however, I do know that if all commercial hospital rates were reduced to Medicare payment rates, a 100% of our hospitals would need subsidies to survive, not just the 12 that are currently receiving them. And they would certainly not be able to afford the labor settlements they have recently agreed to.

Specific concerns we have about the bill include:

CMS reported just two weeks ago -- CMS is the Federal agency responsible for the rule, wrote the

rule, interprets the rule, and also enforces the rule -- they reported two weeks ago that that 82% of hospitals are complying with at least one of the two prongs in the Federal transparency rules, while 70% are compliant with both. CMS has announced that they will take more aggressive measures to ensure compliance. Already they have increased their penalties to $2 million per year, per hospital for not complying with the rule.

We checked the websites of every hospital in New York City and found that they had published price transparency files on their websites and/or have taken the rule's option of providing a cost estimator for consumers.

What I have here is one of our independent hospitals, a hospital that is very high in Medicaid and Medicare in the Bronx, this is an eighth of what they are required to put online. I didn't want to print out 8,000 pages. But the first prong of the rule says that you have put online, in a machine readable format, every single, price that you have negotiated with every, single insurer.

One of our hospitals has 1,198 separate insurers or different products within insurers that they have

had to negotiate prices for. And that is what is on their website.

Despite CMS reporting 70% compliance, the sponsor of the bill stated on Tuesday that only 6% of hospitals are complying. An outside group reported that only 25% comply -- while others have reported that 60% do. Why this discrepancy between the CMS figure of 70% compliance and these estimates? It is because groups have taken it upon themselves to interpret CMS's extremely complex rule differently from how CMS interprets and enforces it.

We fear this is exactly what the new City office would do. The only entity that we believe should determine if hospitals are compliant with CMS's rule, is CMS. It is their rule, they're requirement, and their enforcement responsibility, and they are now increasing enforcement.

Second, the bill would also require the new office to report on hospital compliance with the IRS's requirements on community benefits -- in it's a federal requirement. The IRS specifically includes in this requirements a variety of community benefits; however, outside groups supporting this bill have financed studies that have completely rewritten the

IRS's definition of community benefits. They have left out whole categories of community benefits recognized by the IRS. Based on these unauthorized definitions, these groups have deemed hospitals deficient in the community benefits that they provide. Given the basis of the outside proponents of this bill, we fear that this is what the new City office will do as well. This also is something that the IRS should determine compliance about --regarding ng its own rules and its own definitions and not a new City office.

Third, the bill focuses almost exclusively on our community hospitals. It virtually ignores the behemoth national for profit health insurance companies that make enormous profits in New York's health care economy and ship those profits out of New York to their parent organizations and shareholders. It is ludicrous to believe that if somehow hospital payment rates were reduced, these plans with share savings with consumers. They would merely add to their profits. The bill also completely ignores skyrocketing, pharmaceutical costs, medical device costs, other supply costs, and increasing costs of labor. Hospitals are part of the health care economy,

they also have to purchase at skyrocketing pharmaceutical prices, they also have to purchase a whole variety of things that are within the health care economy -- everything that goes in to a hospital price includes all of those things as well. So, you cannot just say hospital prices are the following (sic) -- you have to also understand that they are buying in that same health care economy -- where all costs are going up.

Given these reasons, we believe the bill is appropriate and duplicative of Federal regulations.

I would be happy to answer any questions you may have, thank you so much.

CHAIRPERSON NARCISSE: Thank you for your time. I am going to pass to my colleague Council Member Julie Menin.

COUNCIL MEMBER MENIN: Thank you so much, Chair Narcisse.

So, you test... In your testimony you talk about adherence to the Federal rule. I wish I could say that these hospitals had adhered to the Federal rule. You mentioned that you have looked at every, single New York City hospital website, I don't understand how with a straight face you can actually that they

are complying. We spent hours, my team and I, hours, and hours, and hours, on every New York City hospital website. I didn't want to bring too many easels, I just brought a few. Maimonides over there, you have to go five pages to find this Excel spreadsheet. The Excel spreadsheet is 109,000 rows of numerical...

(CROSS-TALK)

DAVID RICH: Yes.

COUNCIL MEMBER MENIN: How can anyone figure out what the price is with 109,000 rows?

DAVID RICH: So, that is one of the prongs of the Federal rule. One prong is that they have to do this and that. They have to have every, single service by every, single payor, every negotiated rate. These are not what they charge. These are what they have negotiated with ever payor. So, that is half of the rule. And it is a huge undertaking to do that. That is partly so that different insurers can use their different algorithms to actually look through all of those prices. That is why it is required to be a machine readable file. That is not something that really meant for the average consumer.

The other half of the rule is what is meant for the average consumer. Which is either posting 300

what they call shoppable services and those prices, or have a cost estimator tool -- one of the two. And most of our hospitals have opted for the cost estimator tool. I should mention that starting January 1st, insurers are required to have that as well. And that will have much more information, because it won't just be hospitals, it will be all different types of providers.

COUNCIL MEMBER MENIN: This is exactly why we need this bill. Because, any consumer, and I say this is a former Commissioner of Consumer Affairs for the City, any consumer cannot make heads or tails of this data whether it's the 109,000 rows, whether it is, uh; Lenox Hill having a file in JSON, which only data scientists [TIMER CHIMES] can read; whether it's New York Presbyterian, where you literally cannot search an colonoscopy, appendectomy, cesarean, you cannot get any information. And I also strongly refute what you say about CMS assessing penalties. To date, CMS has only assessed penalties against two hospitals in Georgia. So, they are not assessing... The federal government is not assessing the penalties. This is why, again, the City needs to act. We are not looking to regulate hospitals. We are looking simply

to have price transparency for consumers. So, that is the intent of the bill. And that is why it is sorely needed.

CHAIRPERSON NARCISSE: Thank you. And I am going to pass it on... Before I pass it on to Chair Schulman, are cost negotiation processes identical with all health care insurance companies?

DAVID RICH: They are not, they really do vary by each insurance company and each hospital. It all depends on what those negotiations are like. Different insurers may want to make sure, because their enrollees are clamoring to make sure that a certain hospital is in their network, in which case they may pay a little bit higher to make sure that that happens. But they also might decide they don't need to pay higher rates at other hospitals that they feel that not many of their enrollees go to.

The other issue between hospitals is, you have hospitals that have certain services, and what are more complicated services that other hospitals do not have. So, for instance, you have a hospital that might have burn units like Jacobi or NewYork-Presbyterian. They have ongoing costs all of the time to keep that burn unit open, even when there are

not necessarily that many burn patients, waiting for the day when, unfortunately, they might have a lot of them due to a fire in the area or whatever the case might be. So, they are going to have higher costs than another hospital that doesn't have that. Same with hospitals that have transplant units. Same with hospitals that are trauma centers versus hospitals that are non-trauma centers. So, they have a lot higher costs that need to be covered than certainly community hospitals might have. I am sure you have all had the situation where you have had a loved one or yourself where you went to the nearest hospital, but then needed to be transferred to one that had other services and more complicated, sophisticated services because those tend to be concentrated in certain hospitals.

So, in negotiations, those things are taken into account as well. Some of that is why there is price variation. But there are a whole lot of reasons why there might be a difference between what one insurer negotiated with a hospital versus what another did. Or one insurer negotiated with this hospital versus what they have negotiated with another.

CHAIRPERSON NARCISSE: Do you believe that the... In your opinion, do you think that the Intro 844 is going to create more problems than solving a problem?

DAVID RICH: My concern about is, we don't know what definitions they are going to use. As I said in my testimony, CMS wrote this rule -- they interpret the rule. They reported two weeks ago that 70% hospitals were compliant nationwide, yet other groups say it's 6%. Well, what are they basing that on? The Federal government is the one that wrote the rule and interprets it and enforces it. Whereas, we just don't know what rules are going to be used by this new City office. And it is the same with the community benefits. One of the unions who supports the bill had financed a study of community benefits, and in that study, they left out whole portions of community benefits that are recognized by the IRS, including education of nurses and doctors and other allied health professionals, including losses from Medicaid, which Dr. Morse talked about very eloquently earlier about how little Medicaid pays on behalf of their patients, really fostering system of institutionalized inequality because of how little they pay for low income patients. So, that is really

the concern that we have. If they were going to use exactly what ,you know, the criteria that CMS is using, if they were going to use what the IRS is using, I think we would have a lot less concern about it. But, given that we keep hearing these difference numbers thrown around, and the actual authority behind the rule gives a much higher compliance number, that is of concern to us. We think it can really cause a lot confusion.

CHAIRPERSON NARCISSE: Thank you, I am going to pass it on to Chair Schulman.

CHAIRPERSON SCHULMAN: Thank you, Chair Narcisse.

So, Mr. Rich, if I heard you correctly you said 70% of the hospitals comply with the Federal price transparency laws?

DAVID RICH: Right, according to the Federal government.

CHAIRPERSON SCHULMAN: Okay. So, my question is, if most of the hospitals comply, why would this bill create an extra burden for them?

DAVID RICH: Well, the way we read the bill, is not necessarily an extra burden on hospitals; although, I think I heard you say the other night that you mandate hospitals to do a variety of things

in the bill, which it's not the way I read the bill. I read the bill as using publicly available information. So, I don't see the bill as providing new burdens. My concern about the bill is using new definitions that the Federal government does not use when it comes to compliance with their own rules.

CHAIRPERSON SCHULMAN: So, the most recent Patient's Rights Advocate Study from 2023, notes that 6% of hospitals reviewed in New York were compliant with the Federal transparency laws, how do you explain the discrepancy between what you describe and what they found?

DAVID RICH: I really can't. I don't know what definitions their using. They're clearly not using CMS's own definitions and their views of compliance. CMS, in their report two weeks ago, where they announced that there were 70% compliance, they said that sometimes outside groups can see that that there is sort of a nonapplicable or an empty space or empty in the... In these huge files, there might be something where there is, uh, a cell that is not filled in, and they said that could be because that hospital doesn't provide that service. Or sometimes they negotiate what they call a bundle, where there

are a few different types of services are in one, in which case, those other cells would be empty.

So, it really takes a lot diffing into these files. What shouldn't take a lot of digging into, and should be improved if you're finding that problem, Councilwoman Menin, with the price estimators, is if there needs to be improvement there, that should happen. That's would... Is what would be most helpful as a part of the rule to consumers are the price estimators, where you can go in, put something in, and it tells you what the price is. And that is part of the rule.

CHAIRPERSON SCHULMAN: Do your hospitals timely and accurately file IRS form 990s?

DAVID RICH: Yes, they do.

CHAIRPERSON SCHULMAN: So, you mentioned before, and I know we have talked about it a little bit, about the prices being negotiated separately between the hospitals and the insurers, wouldn't it be beneficial for you as an umbrella organization to have them all come together to negotiate in a way that leverages lower prices for consumers?

DAVID RICH: They wouldn't be allowed to do that under anti-trust laws. So... Which are pretty stringent. So, they would not be able to do that.

CHAIRPERSON SCHULMAN: The Greater New York Hospital Association has noted that the Centers for Medicare and Medicaid Services has made formal determinations that multiple Greater New York Hospitals Association members follow Federal transparency laws, specifically what number of hospitals have received these formal determinations. Is it possible to submit those formal determinations to the Council?

DAVID RICH: I don't know that I, myself, don't have access to anything in writing; however, what CMS does is they both survey themselves -- the websites -- and if they have found that a hospital is out of compliance, they first require an improvement plan. And then after that is done, and when the... there is compliance to their satisfaction, then they have told those particular hospitals that they are in compliance. I can find out if there is something in there that I can get to you on that. But that is my understanding of how the process works.

CHAIRPERSON SCHULMAN: So, the office... The Mayor's Office Labor Relations was here earlier testifying, I think that you might have been here, so, they said that there were two major hospital systems that refused to talk to them or respond to them. So, is that something that Greater New York can help with? Because that is part of the many reasons we are trying to do this transparency [INAUDIBLE]... (CROSS-TALK)

DAVID RICH: We can certainly look into that. I don't know about those specific situations, because, again, when it comes to negotiations, they need to be separated, and the hospitals can't really talk to each other about those. But we can certainly look more into that.

CHAIRPERSON SCHULMAN: So, if I were a patient trying to understand what a health care procedure would cost, how would I go about getting that information?

DAVID RICH: So, you should be able to, assuming compliance with the Federal rule, go to their website, and there are one of two things that the Federal government requires, one, is that they put the prices for 300, what they call shoppable

services, sort of like the most likely services that you.. Are not emergency services, obviously; however, they are very important services, that you would have the time to actually ,you know, okay, it costs this much as this place, it costs this much at this place, I think I will go to this one, because it is less expensive -- or, put up a cost estimator tool so that you can put in what you are looking for. And that can go far beyond those 300 shoppable services. That can actually include a lot more in the cost estimator than the 300 shoppable services that are part of that option. You have the one option or the other option. So, again, I think there are ,you know, there are two parts of the rule, there is this part, which is extremely hard to comply with, as you can imagine, again that is not meant for the average consumer. I mean, I agree with you, that’s crazy. You can't go through this as the average consumer. But, the other half of the rule is really what is supposed to be the consumer oriented piece. Which is either the shoppable services being posted or the cost estimating tool.

CHAIRPERSON SCHULMAN: What portion of overall hospital expenses are spent on uncompensated or charity care?

DAVID RICH: It depends very much on the particular hospital. I can tell you that in terms of community benefits, it is approximately 8%. When it comes to charity care, it is actually a lot lower than it used to be, because we used to have -- before the Affordable Care Act, we had about 14% uninsured; we now have 5% uninsured in this state, so it is a lot lower. But, I would have to get you the average. I don't know if off the top of my head.

CHAIRPERSON SCHULMAN: Do you know how it differs from large hospital systems versus safety net hospitals?

DAVID RICH: Uh, I do not know for sure. I do know that New York City Health + Hospitals does see more uninsured than a lot of either the safety net or the other hospitals do. But, uh, it can vary amongst different hospitals. The safety net hospitals, mainly their problem and why they need subsidies from the State, is mainly Medicaid underpayment being their problem even more so than uninsured. Although, obviously, we have a huge problem with uninsured,

undocumented immigrants in the City. And, so that is something that we are all sort of supporting legislation in the State budget to do something about by enrolling them in the Essential Plan for instance, so that they can actually have health insurance.

CHAIRPERSON SCHULMAN: Okay, thank you. Thank you for answering my questions.

DAVID RICH: Sure.

CHAIRPERSON NARCISSE: Thank you, again for being here.

Why would a service at one hospital cost more for the same, identical service?

DAVID RICH: There are a variety of reasons. Some hospitals, as I mentioned before, can be more expensive than others, because they are the ones that have all of the... they see the sicker patients. They might see the people who are transferred from community hospitals to them, because they have the expertise to deal with whatever the issue that they have. So, the one hospital, it might be a lot less of a price that is negotiated with the insurance company than the one that has the much more... sees many, more sicker patients, but also, uh, has the expertise to deal with a particular problem. So,

that can be one of the reasons. And, then, also a lot of the standby costs that I mentioned, that some hospitals have standby costs, because they have to have burn units at the ready all of the time... (CROSS-TALK)

CHAIRPERSON NARCISSE: I... (CROSS-TALK)

DAVID RICH: or they have to have... I'm sorry, I don't... (CROSS-TALK)

CHAIRPERSON NARCISSE: I got you on that. But, I am just saying, if it is identical. Let's say the person does not have a preexisting diseases that we are talking about, maybe be complicated or a complex case, but we are talking about the same, identical procedure.

DAVID RICH: Part of the reason why it is different, is that one insurer negotiated one price for the hospital, and another negotiated another. I am not privy to those negotiations that each hospital has with the insurance company, but there might be different reasons why an insurance company would say, okay, we are going to negotiate a higher rate for this for you, but we are going to negotiate a lower rate at a different hospital.

There could be all kinds of reasons that an insurance company would do that, including how many of their enrollees actually go to that hospital. You know, their view of the quality at one hospital versus another -- a whole variety of things.

CHAIRPERSON NARCISSE: Because you have hospitals in the same network that more likely the negotiation is the same, and, yet, the cost is way different.

DAVID RICH: They could be different based on, uhm, one of the things that I mentioned before, which is that ,you know, a lot of the systems are built around the academic medical center. So, think of ,you know, some of the Manhattan academic medical centers are Montefiore, they may have... They may have a hospital in Brooklyn that the insurance company says, look, I'm gonna pay you more at the Manhattan place, because it is more expensive; you have more expertise, you have more of the equipment that's necessary. But that one that is in ,you know, the other hospital that's in your system, doesn't have all of that -- they often have to transfer someone to the larger academic medical centers. So, they may negotiate a lower price for the services at that other hospital within the same system.

CHAIRPERSON NARCISSE: I got that. But, now, when it comes to a person paying, so that is the reason we are here. We just want transparency. So, before you go, like, thinking it is an identical procedure, and you have to pay, and most of the time those are uninsured, do not have this kind of money.

DAVID RICH: Yes, so... (CROSS-TALK)

CHAIRPERSON NARCISSE: And before they come, they need to know how much this procedure is going to cost them. And it has to be crystal clear on your websites. Those are the things that we are looking for personally... (CROSS-TALK)

DAVID RICH: Correct. Absolutely, no, I agree with you. And that is that second consumer oriented prong of the regulation that I mentioned, that if it needs to be cleaned up, or websites need to be cleaned up, that is true, but that is a federal requirement, and as CMS said two weeks ago, they are going to step up enforcement quite substantially. So, I agree with you.

CHAIRPERSON NARCISSE: And we are not here for regulations. We are here for transparency.

We have now been joined by Council Member Hudson.

I am going to pass it on to my colleague comfortable for questions.

COUNCIL MEMBER FELIZ: Thank you, just want to thank, uh, Council Member Julie Menin for your leadership on this issue, and I want to thank our two chairs, Chair Narcisse, and Chair Schulman.

So, a few questions. So, your position is that ,you know, obviously have some federal regulations, and that hospitals are already complying, and that this bill is somewhat duplicative. So, if it is duplicative, how would it harm our hospitals?

DAVID RICH: My concern is, and thank you for the question... You have in your district one of those safety net hospitals, certainly that cannot make it on Medicaid and Medicare alone. So, thank you for your support of them.

The problem that we have is, we are not sure that it would be interpreted or the federal rule would be interpreted in the same way that the federal government does. It's the federal government that the... that enforces the rule. They are the ones the hospitals have to follow. They are the ones who could potentially be penalized $2 million, which is now the penalty for not complying with the federal

rule. So, that is what they have to follow. I don't know what the City group would come up with. I mean, they... They're already apparently, a lot of the advocates, are not agreeing with the 70% that the federal government... the compliance rate that the federal government says exists. They say that it's 6%. But, I have no idea what that is based on. I know that the federal government is basing it on. They're basing it on what is in the rule, what's required, et cetera. But, we just don't know, and that is why we are concerned. Again, if it were completely duplicative, I don't know why you would need it if it were. But, if it were completely duplicative, and they were using the exam same rules, the same compliance terms, then I don't think we would have as much concern about the bill. But, it is very unclear what the criteria would be.

COUNCIL MEMBER FELIZ: So, wouldn't a better approach be to ask the federal government and the City Council if we have [INAUDIBLE] to set some clear or much more clear definitions on the issue, rather than opposing a bill that would strengthen regulations... or transparency... (CROSS-TALK)

DAVID RICH: I think there is always... there is always room for more clarity. Our hospitals are regulated by so many agencies at the federal and the state level, and a lot of times rules are less clear than they could be and require interpretation. And I think that is one of the things in the report that CMS came out with two weeks ago, where they said, we are committed to, first of all, making sure that the that the 30% that aren't complying are complying. But, number two, if there are areas where we can be clearer, they provide a template for hospitals to use now to come out with these for instance, uhm, but if there are templates that we can use and other enforcement measures we can use, and other ways we can make it clearer, we intend to do that.

COUNCIL MEMBER FELIZ: Two more questions.

Just curious, what is the most you have heard a hospital -- any hospital -- charge for a COVID rapid test?

DAVID RICH: I... (CROSS-TALK)

COUNCIL MEMBER FELIZ: Seen or heard of?

DAVID RICH: I honestly have not either. So, I have not had a complaint brought to me about a charge for a rapid test, so I am not sure.

COUNCIL MEMBER FELIZ: Right, but putting complaints to the side, what is the most that you have seen a hospital charge for it? Have you looked into prices for that... (CROSS-TALK)

DAVID RICH: I honestly... I honestly have not. All of my COVID tests have been at CVS and free. So, I am actually not sure.

COUNCIL MEMBER FELIZ: Okay.

And approximately how much time and effort do you think it will take to actually -- if you are a patient going to the hospital, to look on line and get the actual prices for these different services?

DAVID RICH: I'm sorry, what was the first part of the question?

COUNCIL MEMBER FELIZ: If you are patient going to the hospital, how much effort would you have to make to go online and start looking into the different prices of different services for whatever services you are going for?

DAVID RICH: What should be, under the Federal rule, is that hospitals on their website, either the prices that they have negotiated for 300 different shoppable services, meaning things that they would most likely be going to the hospital for and looking

up prices for -- or they have a cost estimation tool that will allow them to put in, "Here's my issue", and the price would come up.

And I should ,you know, as I mentioned before, the insurers now under the federal rules, are going to be required to have those cost estimators by January 1st. It is more complicated on their side, because, as I have said before, hospitals are not the only part of the health care system. There's pharmaceuticals, there are other providers, there are freestanding for profit ambulatory surgery centers, et cetera. So, theirs will have a lot more in it than the hospital costs alone.

COUNCIL MEMBER FELIZ: Yes, well, I am just going to say [TIMER CHIMES] those are all good ideas, uhm , but ,you know, we should... the federal government works very slowly, and we shouldn't wait for them. And ,you know, people are flying to the hospital for medical emergencies, you know, I think they should get clarify pretty fast. Thank you.

CHAIRPERSON NARCISSE: Thank you, Council Member Feliz.

Now, I will pass it on to my colleague, Council Member Brewer.

COUNCIL MEMBER BREWER: Thank you very much.

We do get a lot of constituents calling us, as you can imagine, because, they don't understand the bill that they received. And, it's ,you know, they have insurance, they don't have insurance, but usually they have insurance, it just is very complicated. And maybe they have not had the expertise to go on the website, or maybe their insurance just stated, "You have to go to this hospital for this kind of procedure, and that is your only choice." So, they go there, and they get the bill, and it is confusing.

So, it is my experience so that I ,you know, I have the clout, I call the hospital, sometimes talk to the president of the hospital, I know them all, I have all their cell numbers, all of their numbers, and I am able to arrange that this is not... often, it's usually wrong, to be honest with you, usually they should not have been charged, or maybe it is my calling them that reduces it and clarifies it. But, that is not normal, not everybody can do that.

So, I guess my question is... And it does happen frequently -- so my question is, it seems to me that something, as this bill, we know, like, we have the

Public Service Commission, Con Edison is a mess, you cannot get information from Con Edison. You know, I have the numbers, I can call, but most people can't. They don't understand the bill. Why did they just get a $4,000 bill? I love the Public Service Commission, you send your note there, there's an investigation, and you get an answer.

Something like that, I think is a little bit what the Menin bill is trying to address. How do you answer the fact that people have so many questions about their bills; it's hard to get answers. And do you not think that something like this would be of a assistance to the public?

DAVID RICH: Uh, first of all, it shouldn't be as complicated as you're describing. And, that is something that should actually be improved upon. I do know that all of the hospitals under New York State law are required to put on the bills, ,you know, here is where to call, here's who to deal with, here's how you can find out about our financial assistance plan, et cetera.

But, yes, I know that it can be very complicated. I think these transparency laws from the Federal governmental are going to be very helpful, especially

even more so than the hospital transparency law... the insurers transparency law. The insurers are the ones who know what they have negotiated with each and every hospital. They are the ones that are going to pay the vast majority of the bill. They are the ones who know what you have used of your deductible so far this year -- the hospital does not know that. They [the insurance company] would know ,you know, what the co-pay is. The hospital would not necessarily know that. So, I think that there is a lot of work to be done still to simplify all of this. I think, again, I think the federal law is one that is in its infancy. It's only two years old -- well, the regulation is only two years old. And I think there are kinks to be worked out there, but I think there is going to be a lot more transparency to come -- especially when the insurers are required to be transparent as well.

COUNCIL MEMBER BREWER: I appreciate that. It is my experience that you are not always able to under your insurance to shop for the least expensive. It is more, "This is where you need to go," and then when you... Like I said, you often get some information that is not clarified. Those 800 numbers

are challenging. Right? I mean, they don't always have somebody answering it, and when they do, you don't get the kind of satisfactory explanation that I hope something like a PSC (sp?), which is sort of what I am calling this, would give you.

So, in this very complicated city where we have excellent health care, but I think we do need something that helps us understand what it is that we are accessing and how it is different or similar, et cetera. Thank you.

DAVID RICH: Sure.

CHAIRPERSON NARCISSE: Thank you.

I am now turning back to Council Member Menin.

COUNCIL MEMBER MENIN: Thank you so much.

I just have a couple of followup questions.

Council Member Feliz was talking about if you knew about the disparate costs of COVID tests. So, city workers were charged by Montefiore a $1,000 for COVID test. Do you know why they were charged a $1,000 for that COVID test?

DAVID RICH: I do not. I don't know every, single specific hospital situation there. So, I do not know. I don't even know that story. So, you would have to ask them.

COUNCIL MEMBER MENIN: Okay, we know that is a fact, and I think you will hear about that testimony later today. So, that is obviously very troubling -- when COVID tests are free -- and for any hospital to be charging a City worker a $1,000 for test is obviously unconscionable.

Two more questions:

We heard from the administration, specifically Claire Levitt from OLR, testify that she tried to meet with several hospitals to lower prices, and the hospitals refused to meet with OLR.

Do you know why that is?

DAVID RICH: I do not know. I don't know about those specific circumstances, I really don't.

COUNCIL MEMBER MENIN: Okay... (CROSS-TALK)

DAVID RICH: I mean, OLR uses, from my understanding, is that they rely on private insurance companies who have negotiated those difference rates, including Empire for the most part. So, the rates that they are... that they are paying are ones that were negotiated between the insurance companies that they have... They mentioned they're putting out an RFP, that will be the same thing. They don't actually negotiate those rates themselves, but I do

not know about the specific situations... (CROSS-TALK)

COUNCIL MEMBER MENIN: Okay, it is just obviously very troubling when The City is trying to lower costs, and the City workers and retirees comprise 10 to 15% of the population. So, the City is trying to harness its purchasing power, but the hospitals won't even meet with them.

My last question, is in your testimony, you spoke about the fact.. And I am going to read this sentence, "It is ludicrous to believe that if somehow hospital payment rates were reduced, these plans would share savings with consumers." I strongly rebut that. If you look at other jurisdictions that have done price transparency -- the state of California saw 20% reduction in some savings; the state of New Hampshire 5%; the state of Massachusetts similarly.

So, obviously we know price transparency works. That is the intent behind the bill -- to drive down costs and to give consumers the valuable information they need to be able to look at the different prices disparities.

DAVID RICH: Well, it is not the experience we have seen. First of all, you mentioned states, not cities, which I think is a very important distinction. But, I don't see why they... What we have... We have very dominate national for profit, publicly traded corporations who are the insurance companies in this city, including the one that owns Empire, including United Health Care, including Aetna. They have shareholders to answer to. The hospitals do not. They transfer a lot of their profits out of New York State to their shareholders and to their parent corporation -- in Indiana and in Minneapolis -- they don't reinvest that money back in the health care system in New York State.

I think one of the questions is, how are they making such enormous profits off of New York's health care? I mean, that is one of the questions that we think, ,you know, if you were going to have ,you know, an office, I think that would be something that they would need to understand -- particularly seeing the City is contracting with some of those very companies to provide the health insurance for their enrollees.

COUNCIL MEMBER MENIN: I am not going to get into a debate on it, but the issue is really the skyrocketing hospital prices -- whether it is $55,000 and Montefiore for a C-section versus $17,000 at another hospital, whether it is a $10,000 colonoscopy at one New York City Hospital versus $2,000 for another. It is the skyrocketing hospital prices that are causing this issue, and that is why the bill is meant to address the transparency.

So, I don't want to get into a debate, because I know time is short, but I did need to just state that for the record, thank you.

CHAIRPERSON NARCISSE: Thank you, we are moving on with Council Member Yeger for questions.

COUNCIL MEMBER YEGER: Thank you, Madam Chairs

Good afternoon, good morning.

DAVID RICH: Good afternoon.

COUNCIL MEMBER YEGER: We are afternoon now...

You have spoken a lot about transparency and how much you support it. And, but you also don't like this bill. And I am just trying to understand through listening to you today, what exactly about this bill is problematic? Because, it really doesn't require any member of your association to do anything

differently than they are currently doing. The transparency and the information that would be posted would be based on publicly available information. The information is already out there.

DAVID RICH: Our concern is how they would interpret the publicly available information... (CROSS-TALK)

COUNCIL MEMBER YEGER: So, your concern... So, your concern is that if we put this up on a website, people are too stupid to get it? And therefore you're.. (CROSS-TALK)

DAVID RICH: No, my concern is that the fed... (CROSS-TALK)

COUNCIL MEMBER YEGER: you're here to protect us.

DAVID RICH: No, my concern is that the federal government says 70% of hospitals are compliant. And other groups, using who knows what criteria, are saying on 6% are. That is a real problem for us. And I would be glad to know the... (CROSS-TALK)

COUNCIL MEMBER YEGER: [INAUDIBLE]... (CROSS-TALK)

DAVID RICH: criteria that they would use to judge hospitals and grade them on... They have three grades that the federal government doesn't use in

terms of compliance. The federal government says you're either compliant with our rule or you're not. The bill says transparent, satisfactory, or not transparent. We have no idea what criteria they will use for that. And that what is one of the concerns that we have.

COUNCIL MEMBER YEGER: Okay, so, you don't have a problem, I am just trying to parse out, it's a bill, right, it has... It's a draft and some point, I mean, you can be guaranteed it is going to be adopted, it's got a super majority in the Council -- not me -- but a whole bunch of other people -- enough to pass it -- at some point this bill is going to pass. I am trying to understand which parts you have a problem with, and you certainly cannot have a problem with creating Office of Health Care Accountability that would provide recommendations. I mean, how bad can that be? It would [INAUDIBLE]... (CROSS-TALK)

DAVID RICH: I would... I would be... Better is the name... The name does not reflect the bill. The bill says health care... (CROSS-TALK)

COUNCIL MEMBER YEGER: So, we have a problem with the name?

DAVID RICH: No, no, no. I like the name. The problem is the underlying bill focuses almost exclusively on hospitals. There is a lot more to health care and health care costs than hospitals [INAUDIBLE]... (CROSS-TALK)

COUNCIL MEMBER YEGER: Well, let me get to next part of what the office is supposed to do. It is supposed to audit City expenditures on health care. And that is... That is not exclusive to hospitals. It is overall the... How much is the City paying for health care? It pays a lot of money for health care. Kind of want to get a bang for their buck. But, again, it does not implicate necessarily... I mean unless you're concerned that there is something that we are going to find out that you don't want us to, it doesn't... (CROSS-TALK)

DAVID RICH: No... (CROSS-TALK)

COUNCIL MEMBER YEGER: implicate the hospitals at all. The hospitals don't have to do anything. We are going to take information that we already have as the government, and we are going to cobble it all together and make sure that there is one centralized office that has it. That office is going to create a website that will make sure that there is singular

focus by an individual with a team who reports directly to the mayor, who are going to be in a position to try to figure out whether or not the City is paying what it ought to be paying. Maybe it's paying too much. Maybe it's paying too little and the hospitals can make some more money.

But, let's try to that that out. I am just trying to understand that... I'm really... I'm... (CROSS-TALK)

DAVID RICH: We don't [INAUDIBLE] here [INAUDIBLE] objection on is... (CROSS-TALK)

COUNCIL MEMBER YEGER: [INAUDIBLE] I just don't get the objection. I just don't understand it.

DAVID RICH: We don't have a position on the audit.

COUNCIL MEMBER YEGER: Okay.

DAVID RICH: Although OLR had a position on the audit. We don't have a position on the audit. What we have a position on is taking federal rules and regulations and then potentially reinterpreting them in ways that the federal government doesn't recognize, doesn't ,you know, enforce against hospitals or... creating different standards than

the laws that the hospitals are supposed to be following under federal law.

COUNCIL MEMBER YEGER: Okay, but, I want to be clear, this is not an enforcement bill to the extent that there are penalties involved, nobody is getting punished, there is no fine, the City is not imposing a fine on a hospital that doesn't do x, y, and z in compliance. It is simply taking information and putting it in a... in the public domain, so that A) members of the government, people who are supposedly on the board or directors of this municipal enterprise, and, also, the general public, can have an opportunity to see.

If you are saying that the people are not ,you know, able to understand it, well, that's okay, we... there's a lot of information on websites that we don't understand. I don't understand it. That's fine. But, I just don't get the objection, because the hospital doesn't have to do a single thing if this bill passes other than continue to do whatever it is that it is doing. All that will happen is that the City, the payor, the customer, will have a little bit more information. And I think more information is always good. [TIMER CHIMES]

I guess that is not a question, so... Anyway, I appropriate you being here. Thank you very much.

DAVID RICH: Okay.

CHAIRPERSON NARCISSE: I, believe it or not, am in agreement with the statement that you made.

And just... We are not regulating. And I have said that many, many times. We are just here to look for transparency. There is not regulation. This is not our lane, and I love to stay in my lane. So, I am staying in my lane. It is just transparency, making it more accessible to the people that we serve. That's all.

So, having said that, I want to say thank you, anyone else have... (CROSS-TALK)

DAVID RICH: Thank you...

CHAIRPERSON NARCISSE: We have no more questions, so thank you for your time. We appreciate it...

DAVID RICH: Actually, Council Member, I just want to thank you for your letter and your advocacy for the State Budget, especially as it related to Medicaid and safety net hospitals. We really do appreciate that.

CHAIRPERSON NARCISSE: I believe health is wealth. So, I am going to keep on fighting for quality health care. And, thank you for your service.

DAVID RICH: Thank you.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: We are going to move onto the next panel in person: Cora Opsahl with 32BJ, Henry Garrido, and Pat Kane.

We will start with Cora when you are ready, please, thank you.

CORA OPSAHL: Good afternoon, thank you so much for the opportunity to speak this afternoon.

My name is Cora Opsahl, and I am the Director of the 32BJ Health Fund. I am testifying today in support of the legislation to establish an Office of Healthcare Accountability within New York City. The 32BJ Health Fund provides health care benefits to over 210,0001 32BJ union members and their families. Our members are the front-line workers that keep our buildings in order and airports and schools moving.

The Health Fund provides health benefits with no employee premium sharing. As a self-funded plan, the price of health care directly impacts our budget and ability to keep costs low for our members. Currently,

the 32BJ Health Fund has access to hospital pricing information through the claims data we receive from our third-party administrator. We have a 20-person analytics and data engineering team that uses this information in addition to other publicly available data, to drive our decisions. However, as has been mentioned in other testimony, because a recent report showed that less than 10% -- in fact only 6% of New York City hospitals are in full compliance with the federal transparency laws, we are very limited in our ability to make valid comparisons across hospitals and providers.

It is also very challenging to gather data from so many different sources and do the work to make sure it is viable -- and we have 20 folks to do that. For employers that don't have the analytics team, uh, like we have, it is even more challenging.

A centralized entity that collects and disseminates this information would be a game changer for us and many other employers who are trying to manage hospital prices.

We are often asked why 32BJ Health Fund focuses so much on hospital prices. While we understand that many factors contribute to expensive health care, the

data indicates that the single biggest escalator is hospital prices. Since 2009, the Bureau of Labor Statistics has tracked an 80% increase in hospital prices, compared to a near 30% increase in drug costs, and near 50% increase in healthcare costs overall.

Hospitals account for nearly 40% of all dollars spent on healthcare in New York State, compared to just 14% spent on drugs. By contrast, we at the 32BJ Health Fund, spend about 5% of our total operating expenses on our internal overhead and external administration costs.

So, in the end, hospital prices really matter.

We also know that the price of care in New York City varies by a wide margin. The price the Health Fund paid for colonoscopies between 2019 and 2021 varied from $2,185 at [TIMER CHIMES] New York City H+H to $10,368 at New York Presbyterian. We need transparency in hospital pricing, and explanations for the wide differences in price for the same procedures.

Because, again, hospital prices matter.

We understand that different hospitals have different costs and requirements. We support efforts.

to more fairly compensate our public and safety net hospitals whose financial profile often stand in stark contrast to many of the City's more well-heeled private hospitals. Better data will allow us to take this into consideration in what we pay different hospitals.

For public and safety net hospitals, prices truly matter.

In sum, the Office of Healthcare Accountability will provide us with important information to support market driven solutions to high healthcare costs. It will also reinforce New York City's commitment to federal transparency laws thereby motivating more hospitals to comply.

We commend the City Council for its groundbreaking work on this legislation.

Thank you for the opportunity to speak.

CHAIRPERSON NARCISSE: Thank you, we will now move on to DC 37.

HENRY GARRIDO: Good afternoon, Chair Schulman, Chair Narcisse, and members of the Health and Hospital Committees of the New York City Council.

My name is Henry Garrido, and I am the Executive Director of DC 37, the largest union in the City. We represent 150,000 members and about 90,000 retirees.

I'm here today to support Intro 844, which would establish an Office of Healthcare Accountability. We appreciate councilmember Julie Menon for sponsoring the bill, and the chairs, for holding this hearing bringing this most important issue to light.

For years, the hospital prices have steadily increased, and, as a result, it is now the biggest escalator of hospital costs and health care costs overall.

In 2021, the federal government passed a law that required hospital to post charges, negotiated prices, and cash prices. Unfortunately, much of the data posted in -- unreadable -- machine-readable file formats that make it difficult for patients and organizations to understand the information.

Intro 844 takes the federal law further by creating an Office of Healthcare Accountability that would collect and publish pricing data that hospitals should already be posting and make it easier for the public to access the information to use.

The Office Of Healthcare Accountability would have the authority to make recommendations on how to lower the cost of healthcare. It would also be required to create a publicly accessible website that provides information on the cost of hospital procedures, and summarizes the cost transparency of each hospital. Finally, where feasible, the office will report on the factors external to hospitals, such as the operating and nonprofit margin of major insurance providers.

This office would help patients maneuver through the complex world of hospital pricing for approximately 300 procedures, since the information will be housed at one specific site and provide a standardized list for all procedures. This will make it easier for patients to accurately compare prices between the different hospitals.

As consumers, we can price comparison shop for gas, groceries, and even expensive items, such as homes and automobiles; yet there is no mechanism available for patients to compare the cost of medical procedures by hospitals. These checks and balances in Intro 844 provide much needed transparency and information in hospital pricing.

For too long, these private hospitals have gone unchecked and allowed to charge whatever they want it for various procedures. They need to be held accountable for their pricing structures.

I won't read the rest of my testimony, because I would like to address something that was said earlier by The Greater New York Hospital Association.

If you take the [TIMER CHIMES] price comparison requirement was named for Columbia Presbyterian, for instance, the shoppable convenience list that they put up of the 70 procedures online, you find most of them -- pricing for insurance for uninsured patients, depending on your provider. The numbers are just untrue. Numbers don't lie. But, people use numbers to lie repeatedly.

We need an office that would really hold those costs accountable, and to demonstrate the true costs to the patients. *Not an estimated cost, based on factors that they have already filtered.* But, the actual costs to the patients and workers.

Let me just say lastly, that as I mentioned earlier in my press conference, 10 years ago, the costs of providing health care for City workers was $3 billion, high enough. About $800 million of that

was hospitals. Ten years later, that cost is now $12 billion of that, hospitals are 62%. It doesn't take a genius to say, even when the number of procedures went down during COVID, where selected procedures were reduced, because you didn't have elective procedures any longer, the costs went up by a 150%!

So, tell me how that is possible? How is it possible for hospitals to keep robbing workers of their hard earned dollars? And without any accountability at all. So, for that, we support Intro 844. We will submit written testimony for your consideration, Madam Chairs, and thank you for listening today.

CHAIRPERSON NARCISSE: Thank you.

Now we are moving on to NYSNA.

PAT KANE: Good afternoon.

My name is Pat Kane, and I am the Executive Director of The New York State Nurses Association. I am here representing more than 42,000 nurses across New York State. I really want to thank you all for the opportunity to testify today and for your really important work on this issue that we have been talking about for a long time at our union.

The rapid rise in the cost of health insurance driven in a large part by escalating hospital prices is well established in 32BJ's report and other research.

I want to focus my remarks on how this problem is impacting nurses and other health care workers in terms of wages and working conditions.

Our members went through an extremely difficult and traumatic experience during COVID. Hospitals were already short staffed due to the workforce practices of many hospital systems. And the pandemic only revealed and worsened those conditions. The hospital industry has experienced a wave of consolidations, and the creation of large hospital networks -- that are also acquiring physician practices and other health care services -- to maximize their market power and generate profits.

These hospital networks are all nonprofits. Because New York State law does not allow for private corporations to own or operate hospitals.

And, despite their nonprofit status, these networks increasingly act like for-profit corporations. They are driven to reduce their labor costs by understaffing and underpaying to increase

their revenues by shedding unprofitable services like psychiatric and maternity services that our communities so desperately need. They focus their marketing efforts on patients with private insurance and leave low-income, under insured and Medicaid patients for the safety nets to handle.

In pursuing this business strategy, wealthy hospital systems force consumers, patients, and their employees to pay unconscionable prices for services. Some of these hospitals, as you know, charge three or four times the rates paid for the same diagnosis by Medicare.

Nursing is already one of the most dangerous jobs with very high rates of injury and illnesses contracted at work. COVID only made the physical and mental toll worse. But, when we went into bargaining for our private sector contracts last year, the hospitals took the position that they could not afford to pay the nurses health benefits, and that we should reduce the quality of that coverage and pay more in premiums and co-pays.

This stance was especially infuriating in light of the facts that one of the major drivers of [TIMER

CHIMES] high costs is the pricing and business practices of the same hospitals.

We had to push back to preserve our coverage, and the high costs of health care were a major sticking point in our negotiations. In the end, we fought back to win fair wages, and we preserved health benefits of active and retired members, so that we could continue to provide the care New Yorkers need.

I want to cite just a few figures before I close my comments.

The New York Presbyterian Hospital Network has some of the highest charges for many procedures in the City of New York. In 2021, according to their financial statements, Presbyterian made more than $1 billion in profits, and has $19 billion in assets. The CEO of Presbyterian made more than $11 million in 2019 according to federal filings. I could give many similar examples from other big hospitals networks.

We think enough is enough. We have to start to fix the problem, crack down on these abusive hospital business practices, and for these reasons NYSNA strongly supports and urges the Council to pass this legislation.

Thank you.

CHAIRPERSON NARCISSE: Thank you.

If we can keep the answer to the questions a little tight, because either we have to leave the room and go somewhere else, because we have a second hearing, or we can try to do our very best. So, we are going to do our best. No rush, because this is important.

What have you observed about the cost discrepancies in the City when it comes to health care?

PAT KANE: Sure, so I will take that first. You know, I think that when we look at our data, it is really clear that there are cost discrepancies across the board. So, and I know Council Member Menin has mentioned the colonoscopies, uh, we have to look at our claims data, and we can see that you can go and get... And the colonoscopy is a great example, because it is about as ubiquitous of a surgical procedure as a non-clinician can talk to. I am not a doctor. But ,you know, we see that it is somewhere for $2,000 at New York Health + Hospitals or $10,000 at New York Presbyterian. We have seen the same thing when you look at vaginal deliveries or cesarean sections, or things like ,you know, basic heart

procedures. And the wide variety also doesn't correlate to quality. And, so, from us, our data really shows that there is no -- from what we can tell -- any really reason for the wide variety and disparity in pricing.

CHAIRPERSON NARCISSE: And the colonoscopy part is something dear to me, because I am always in the procedure room for colonoscopies.

PAT KANE: I'm sorry to hear that. (LAUGHING)

CHAIRPERSON NARCISSE: (LAUGHING) No, I help a lot, especially when there is no staff. So, I am the staff for my partner -- back in the day.

So, they don't pay that much in Brooklyn that is for sure.

Thank you. Yes, Henry?

HENRY GARRIDO: Yes, I was going to address that. In addition to that, I think you heard earlier about the issue of a simple COVID test being charged over $1,000. It is actually over $1,150 by one hospital system over another with no possible explanation.

And I want to reiterate something that was also mentioned by Council Member Menin, which is, as the head of the MLC, right, uh-co-chair of the MLC, the head of MLC, Harry Nespoli, went with the City and

requested to meet with the hospital systems to try to get an understanding from their perspective of why there are such price discrepancies. Right? And there were three hospital systems that flat out refused to meet with us. Flat out refused to the City. And when we asked why, they said, "Because we don't have to." That is that kind of arrogance that we have seen by these hospital systems. And, so, when you look at a explanation for the discrepancy, even within the same facilities, of the same hospital network, two hospital facilities, located in different locations, and because we are City workers, we are being charged significantly more than what, uh, say a private insured patient was. What's the explanation for it? They do not provide one -- because they don't have to.

This is the kind of arrogance that we need to eliminate. And this Intro 844 would begin to address that by making the data publicly available.

CHAIRPERSON NARCISSE: All right.

How do hospitals play a role in health care costs?

PAT KANE: Hospitals are one of the major drivers of health care costs. And those costs are passed on

to a lot... You know, not just union members, right. Health care costs drive inflation. It really affects the quality of people's lives. As we are talking about -- and as somebody previously mentioned -- folks are often put in a position -- whether they are represented for collective bargaining or not -- because of the increased health care costs, they are actually looking at trading their livelihood, their ability to earn a decent wage, or their health. Which is really ridiculous. Hospital costs contribute astronomically overall to health care costs. You know, and this is one of the reasons that we try to keep patients, as much as possible, out of hospitals. We try to keep people healthy. Because we all know that inpatient care is definitely more expensive than preventative care.

CHAIRPERSON NARCISSE: I would say Amen to that, if I was in church.

How does health insurance companies play a role in health care costs?

HENRY GARRIDO: They're enablers. They basically, a lot of the times... One of the concerns that we have is that there was no transparency by which the insurance companies negotiated rates with certain

hospitals. And they made it explicitly so in the contracts. So, even the ability audit back prices that were higher, were explicitly prohibited in some relationships between the insurance and the hospitals. For that reason, I think they are enablers. And we need to break that relationship in a way that benefits the patients and the consumers -- and not this whatever relationship they have -- and I think you heard earlier one example of what happened to the fight between United Health Care and Montefiore some time -- for that year, those patients in that area, where there is essentially -- and I will say it -- a monopoly in the Bronx, went without services or had to pay out-of-pocket just because of a dispute between the two, without transparency as to what the dispute was really about. Right? *Other than greed.* I will say it. Greed.

So, this relationship is an incestuous one, and one that this kind of bill could go at the core of breaking. We need to do this, and we need to do this now.

CHAIRPERSON NARCISSE: Thank you.

How do private health insurance rates compare to public health coverage such as Medicare, Medicaid, and the essential health plan?

CORA OPSAHL: So, excellent question. So, it is very... All of our data show that as a commercial payor we are paying multiple times more than what we would be paying in Medicare. But 32BJ Health funded an analysis of what our claims would have been from 2016 to 2019 had we paid Medicare rates. We would have saved $1.1 billion during that time frame. And while it is not quite the same numbers -- as Henry can speak to -- what the City could save when we are looking at the same type of comparison. But, right now when you are looking at things where 400% of Medicare at some of these not for profit private hospitals, you have to wonder why our commercial payors really ,you know, are really being forced to pick up the difference in those prices.

CHAIRPERSON NARCISSE: Do other cost or factors create a barrier to care for your members?

HENRY GARRIDO: Yeah, I think location. You know, when we talk about zip codes and the location... I was particularly enraged when I became the head of the union in 2015 and found that there were very

little providers, and in many instances no providers, for instance, in the Bronx when I am representing 30,000 people there. And there is essentially a monopoly as I said with some providers. And the fact that people have to travel and also get their care in a very specific zip code, it's a problem. Right? Especially for senior and people that have mobility and transportation issues -- it is a big difficulty. I also think the true monopoly of specialists who refer people back to hospitals. One of the strategic pieces that they did is, "Well if I do all of the specialists in a particular area, then they can only refer people back to us." So, if you go to see a primary care physician who refers you to a specialist, who then says to you, "I only have admitting privileges with a particular hospital," you have then created a pipeline for that person to not be able to choose between providers, but just basically monopolized the system from the beginning -- when the person goes in with an issue to the end when the person may have to have surgery -- and at the back end, after surgery, post-op services. This means that they can also control the costs of the rates of those particular specialists. That is a

problem. The lack of access and diversity in that has been a strategy.

Secondly, I want to talk about these negotiating pools that they talked about. One of the most difficult things to do, is that these hospitals come in as a negotiating group for rates with already preconceived ideas. It makes it extremely hard for hospitals in the area -- like, we have 100 plus hospitals in the area, but basically we negotiate with the five groups. It makes it very difficult to break that. Now, that might be a business strategy for their end, but for the consumers' point of view, it is horrible. Because ,you know, I think if they come in with a preconceived notion of what the cost would be rather than what the actual cost is, then you have a problem. Right? And your only option is, If I don't take your pricing, you're going to put me out of network, and my members -- the members of the City unions, the City workers, are going to get upset , because you took a network out. Here is your model. Take it or leave it.

We need to do better than that. And I think one way that we can do better is by having true transparency in the cost disparities that Cora

mentioned that we have seen across the board in both public and private institutions.

And, also, let me just say, hundreds of millions of dollars of taxpayer's money is given to these hospitals because they are known for profits. They don't act as such. Many of them don't. And so, we should hold all of them accountable to say, hey, we are giving you massive tax breaks -- on property taxes, on a number of things -- what are you really doing for the public? What are you really providing? Are you diverting patients who are underinsured to another public service, to H+H, because they can take them and you won't?

CHAIRPERSON NARCISSE: If there is one big, positive thing you can say that can come out of Intro 844, what would it be? That question is for all of you.

PAT KANE: I think ultimately, just having the tool, having the transparency, and really empowering patients, workers, you know, to see what the prices are and really... You know, it gives people the power to create different networks. In our fund we are self-insured. And ,you know, we are sitting [INAUDIBLE] plan, we are sitting across from those

hospitals. And when we try to bring up prices and how to generate savings through looking at prices that different hospitals are charging -- and their networks, they tell us that they cannot talk about that. They won't talk about it. So, I think just ,you know, being able to really rein in the costs, see what's going on, and generate more healthy competition. I was thinking today ,you know, I have never really seen... I worked in the OR for 30 years at a Staten Island hospital, I never a saw a designer appendectomy that was worth that kind of price tag as opposed to a regular appendectomy. Like Anne Goldman said earlier, it's just an appendectomy. Right? And ,you know, we are here to provide the same quality care to our patients regardless of their zip code and regardless of what patients are charged. We believe very strongly that health care is human right.

And I also want to say ,you know, as far as nursing goes, I don't think in your hospital bill that you will find a separate charge for nursing, right? Hospitals are still billing for nursing -- doesn't matter what the intensity is -- as part of like a room and board charge.

CORA OPSAHL: I would say ,you know, similar to what you are saying, that transparency is the win here. Right? You can't fix the challenge of health care and health care affordability if you don't know how much it costs.

CHAIRPERSON NARCISSE: Thank you.

HENRY GARRIDO: I would say evening the playing field, right? Give the consumers a chance. We negotiate contracts for a living, and we would like to think that we are really good at it. But, we cannot negotiate a contract if the rules are fixed so that you already are at a disadvantage. And part of the rules being fixed is the way the pricing is skewed to certain hospitals and the way they play with the numbers. That makes it almost impossible for you to have an honest negotiation. And evening the playing field, I think, is critical in this bill.

CHAIRPERSON NARCISSE: Thank you.

Now I am going to pass it to my colleague, Chair Schulman.

CHAIRPERSON SCHULMAN: Thank you, I want to thank this panel in particular. And I just... Miss Kane, I just wanted to mention ,you know, it is interesting when Greater New York was here, they talked about the

reason there were discrepancies between the insurers and the hospitals, was that some of them were "specialty hospitals." It sounded almost like we were paying for overhead, for the overhead for these particular specialty hospitals -- which become specialty institutes for various reasons. So, I wanted to mention that.

So, I wanted to ask all of you if you can talk about how hospital pricing and cost transparency impacts negotiations at the bargaining table?

CORA OPSAHL: So, I can tell you that on January 1, 2022, the 32BJ Health Fund removed New York Presbyterian and all of their affiliated hospitals and physicians from the network. We estimated that we anticipated it will save us over $30 million in 2022 alone by removing the highest cost hospitals and affiliated doctors from our system.

You know, I am not the union, that I can tell you that because of this cost savings, the union worked on the residential contract negotiation, and in April of 2022, resolved the residential contract -- being able to grant a $3,000 bonus to their members -- the largest wage increase in history for this contract. And, then, on the employer side, granting a 2-month

premium holiday for the employers, plus holding our premium increases to 3% in 2024 and 2025.

So, that, I would say is really clearly the impact of what understanding our pricing does for us.

HENRY GARRIDO: Since the time of the fiscal crisis in New York, most unions, the public sector unions negotiate... all public sector unions negotiate on the basis of what we call the One Percent Rule. Basically, there is a labor reserve that is set on that one percent. What is the cost of one percent for City workers? That then gets put into the budget. We've heard about it. Since we have recently, thankfully, negotiated a contract for our members, uh, the cost of that one percent has increased exponentially by the cost of health care in fringes that are there, and hospital is the number one reason for it. Even in the rise of costs of prescription drugs, there has been also an increase, we have managed to do an RFP to control that cost. That one percent becomes larger, so; therefore, there is less money for wages for the workers.

We saw, for instance, in comparison where they are being [INAUDIBLE] and out of network, where the workers were able to get more than City workers --

exponentially. So, we felt that this was a big issue. Right? And to the extent that you hear so much about the rising costs of health care, think about, if we were to able to do that and hold them accountable, that $2 billion alone could have been an additional... If you think that cost of one percent is $450 million, you could do that math. How much more could you have paid the workers? And now we have a huge recruitment and retention issue in the City of New York. We have 25,000 plus vacancies. That doesn't include Health + Hospitals. We are looking at the costs and how much people are leaving because we are not able to raise wages. And health care costs is the number one issue for that. Right? We are looking at how public hospitals are now under staffed. And what when the want to recruit respiratory therapists, and nurses, and nurses' aides, and private hospitals are part of the affiliated hospital of supplying, have been able to control their costs in hospitals -- where we have not, because of this kind of situation. And, so, it doesn't take a genius to see the numbers. Right? And the direct effect of having to limit how many raises you can get for workers, and how many salaries

you can do, in a competitive market, most of it is going to your health care. And that is a fact, and that is a fact that we are suffering from.

PAT KANE: [INAUDIBLE] in our most recent contract negotiations, the costs really played a big part with 17,000 nurses in 12 facilities in New York City. The only facility where it wasn't part of our benefits fund, was a Montefiore. And our benefits fund, we are self-insured, it is 39,000 lives that we are covering through the fund. The cost... We were in a situation where that fund would have run out of money this month -- in February -- if we were not able to get... of course, from our side we wanted to increase contributions, and the management side wanted to put... wanted the workers to bear the cost of the increase. You know, we were able to... I think you all know what we had to do to be successful to get the kind of wages that needed to recruit and retain nurses that we so desperately need and maintain their health care.

You know, and I want to say, when workers -- obviously, nurses are paid at a different level than a lot of other workers, and we have been very fortunate... but, you know, for workers, we are

talking about prevention, quality of life, and we all know about the social determinates of health. So, when a worker is forced between health care and a living wage, when you think about those choices, that wage is going to affect their health, their ability to have proper nutrition, proper housing, and all of the other things we know that really impact their need for health care to begin with. So, it really is a Sophie's Choice for most workers. It's just not right.

CHAIRPERSON SCHULMAN: Thank you very much. And I just want to say that I am also committed to helping on the state level, too. Because this is one piece on the city level, but we also have to go to the state and federal level. I mean, I understand that congress is in a different place now, but we have to do this... coordinate it so that this doesn't keep festering and that we can do what we can for all of our workers, because it was so important during COVID and so important to ,you know, as a recent breast cancer survivor, I can tell you that everybody from the techs, uh, nurses, were so kind to me, and so good, and we have to make sure that we give back to them. So, thank you.

CHAIRPERSON NARCISSE: You are trying to say nurses are the best?

We will move forward to my colleague, Julie Menin.

COUNCIL MEMBER MENIN: Thank you so much. I really want to thank all three of you for your very compelling testimony today. And I just have two quick questions.

Without this bill, where would you predict that health care spending will go in the coming years?

CORA OPSAHL: I just have one word -- up.

But, realistically, when we look at how much hospital prices and how much health care spending has increased over the last ten years, especially in comparison to ,you know, even the rising cost of living, it out paces inflation multiple times over. And without the ability to see what we are paying for, it’s just going to go up.

HENRY GARRIDO: And I would add significantly higher. Right? Not just up, but significantly. And, by the way, it’s because of what I mentioned before. Right? Union negotiated positions are not the same when hospitals are either hiding costs or coming in with a take it or leave it attitude that

our members will resent. Right? For City workers and their families, we provide health care for 1.3 million people. It is very hard to say to a member, "Well, this hospital network is not going to be there because of their behavior." So, it is not like what happens with cable when a particular channel is going to be eliminated. You are talking about life and death situations here. People's services, right? And this is not something like you're just going to be doing without a channel. So, it is not only in terms of pricing significantly up, but also, what is the affect on people? We are talking about human beings here. Right? And these hospitals claim poverty all of the time, but yet are able to pay millions of dollars in bonuses and raise the salaries at the same time, with that very irony, the same City workers that they are benefitting from can go years and years without salary increases for the same reason. So, that is an absolute inequitable approach to this. But, I would say significantly up is what we would expect.

PAT KANE: Agreed.

COUNCIL MEMBER MENIN: Okay, and last question, from 2014 to 2020, New York had the highest average

growth in per capita health care spending. I spoke earlier about some other states that have enacted price transparency, what has been your experience in terms of talking to other jurisdictions who have adopted price transparency?

CORA OPSAHL: So, our experience has been, and I know that there is some testimony later from some folks in other states, has been that when we adopt things like this, change does happen. Because, again, I think ,you know, there's the common phrase, "Sunshine is the best disinfectant," and this is true here, too.

HENRY GARRIDO: Yes, and I would say, that, for us, since 2014, we have established a lot of price controls at the early... in order to try to ,you know, help change behavior. Right? We increased co-pays in certain instances to the discourage people from showing up to the emergency room -- where an issue could have been handled through either an urgent care center and, uh, removed co-pays to encourage people to those primary care centers. We did a program called The Advantage Care Physicians, which opened new centers where you are able to get more services from a 24-hour kind of operation and

facilitate the services to steer people away from the hospital behavior.

Uhm, and if you look at, for instance, what Chicago has done as compared to New York with price transparency, their rates have been able to be significantly lower, because the unions have been able to negotiate better rates because the transparency was there. We need the same. And we believe that this is critical to the future of New York. Otherwise, this $13 billion... $12 billion is going to become $20 and $30 billion. Where does it stop? It won't stop. And we need some price control on this.

PAT KANE: And, I think ,you know, what Henry was talking about is an example of having the transparency, but then ,you know, it's what you do with that information. Right? And I think ,you know, New York is a place is where we can really lead the City. It's a place where we can really lead, and hopefully show other parts of the country that this can work for them. But, I think this is an area that once we have this information... We have seen what happened in other jurisdictions, I think we can

really lead on it and make some great changes that will really improve everyone's lives.

COUNCIL MEMBER MENIN: Great.

CHAIRPERSON NARCISSE: Thank you.

If you see us going back and forth, it's that we have to determine whether we are staying here or if we have to transfer to the next room. As you can see, some others are coming. So, I want to say Thank you for your time. Thank you for your testimony. It really gives us some clarification, whether a question from our constituents as well as for us. So, thank you, I appreciate your time.

[TIMER CHIMES]

COMMITTEE COUNSEL: Okay, we are staying in the room for now.

All right, we are going to be moving onto our next in-person... Well, we actually have a highbred panel now.

We are going to have Lisa Young Rubin, Sue Ellen Dodell, and then joining us virtually Marianne Pizzitola.

We are going to start with our in person panelists, and then we move to Marianne virtually.

UNKNOWN: If it is possible to get Ms. Pizzitola on first, we would appreciate it.

COMMITTEE COUNSEL: Okay.

So, we will hear from Marianne first, then. Marianne, you may begin.

MARIANNE PIZZITOLA: Thank you, uh, Chair Narcisse, Chair Schulman, and other committee members.

My name is Marianne Pizzitola, and I am President of the NYC Organization of Public Service Retirees & FDNY EMS Retirees.

We have many concerns about this bill. We have asked the Council to investigate our health care expenditures several times. We contacted the Oversight Investigations Committee several months ago. At the January 9th, hearing on the mayor's bill to amend the Administrative Code 12-126, we specifically pointed out the misuse of health insurance stabilization funds. And in emails to council members, we pointed out the fiduciary failures of OLR in mayoral agencies.

We need oversight and accountability from this Council, not more bureaucracy.

Our fear is that this new office proposed by Intro 844, may be a way for the City and the unions to get around the judges decision in our last round of court. [INAUDIBLE] the current protections that the City Council currently offers to retirees. And why do we think this? Because the City and the MLC have made a practice over the last few decades to water down health coverage, create obstacles in that coverage with prior authorizations, narrowed networks of providers, and increasing co-pays on employees and retirees in the name of savings. They have also repeatedly suppressed the HIPP rate, as per the health savings agreement, which guarantees that the equalization payments will be larger every year.

The City will keep saying that the unions are there [INAUDIBLE] and this is not a way to negotiate savings. We have a bill pending in the Council that would protect the retirees vested health benefits, because the fear the tactics that have been used for savings, and have become victims of it, with their Medicare Advantage schemes.

We hope that vested retiree benefits would not be collateral damage from Intro 844 if it is passed, but we are offering our concerns ahead of your vote.

We have seen several attempts made by the City and the unions to sell off our retiree health benefits in exchange for active raises. What guarantee do we have that this will not happen again for the sake of savings in this new office?

We have raised the following issues several times with OLR regarding overpayment of retiree health care:

Are retirees being overtaxed by the IRS, because the City has their domestic partner on [BACKGROUND NOISE] [INAUDIBLE] plan currently?

A retiree whom the City is overpaying for their spouses health care plans. [INAUDIBLE] City paying for two deceased spouses of retirees for over five years.

And the City paying for a full family GHI plan for a couple on Medicare Advantage.

And these are just a few.

If The Mayor's Office Labor Relations cannot manage its current fiduciary responsibilities, creating another office under the mayor is not going to solve the problem. The wait time currently at OLR to answer a call can be hours. OLR has even used

[INAUDIBLE] health personnel to handle employee and retiree calls in the OLR offices.

We should not be including diminishing care to save money for the City, but real innovative ideas, and we have come up with a few.

OLR and OMB have repeatedly negotiated deals with Labor does water down care -- transfers costs to Labor or the retiree, and that is not a real savings for any of us.

The City added 12 plans in 1986, the idea was more competition would increase service and drive down costs. How we look at finding savings should change, because the City saves [BACKGROUND NOISE] but at what cost? (CROSS-TALK)

SERGEANT AT ARMS: Your time has expired.

MARIANNE PIZZITOLA: The lives of the workers and retirees pay financially.

Please investigate these issues now, as you have right before you. In 1996, Governor Pataki said that ending the state's decades old practice of setting rates for services provided by hospitals would allow competition and push down cost. And 27 years later, we see that didn't go as planned.

But, we are glad to see that the Council is recommending that state regulate hospital costs once again, and we support that. But, here in the City, we would prefer if the Council conducted the investigations into these issues we have raised several times, implement our Blue Panel... (CROSS-TALK)

SERGEANT AT ARMS: [INAUDIBLE]

MARIANNE PIZZITOLA: Ribbon... Our Blue Ribbon Panel [INAUDIBLE]... (CROSS-TALK)

COMMITTEE COUNSEL: Thank you, your time has expired.

MARIANNE PIZZITOLA: And provide enforcement powers to The Comptroller to save our benefits and tax dollars. Thank you.

CHAIRPERSON NARCISSE: Thank you.

And, the next panelist, try to make it short, please, because we have to move out of this room.

SUE ELLEN DODELL: I understand.

My name is Sue Ellen Dodell, and I'm testifying on behalf of the New York City Organization of Public Service Retirees.

The Council doesn't need to create a new office. Under Charter Section 29, the Council already can

investigate any matter relating to the property or affairs of the City. Why isn't the Council providing oversight to demand that OLR will do a better job to ensure that healthcare provided to City employees and retirees is high-quality and is delivered efficiently? Why would you want to create a new office under the Mayor, when the existing office has failed in its fiduciary duties?

Why don't you ask the Comptroller to perform a comprehensive audit of the City's expenditures on health care?

This bill cannot effect the pricing of the pricing of private hospitals. As you've heard, the State used to regulate prices for hospitals, but Governor Pataki removed these regulations in the mid-1980's. That has been a disaster. We need to return to some oversight by the State.

I think it is very telling that you are considering a resolution today that would encourage the State Legislature to create an independent regulatory body to oversee hospital pricing, but you also are considering a bill at the City level that would put responsibility on the Mayor alone to provide for disclosure of the cost of hospital

procedures and to audit City expenditures on health care.

This bill will not help City residents, employees, or retirees get better health care, nor does it control health care costs. Rather than create another bureaucracy, you should mandate a Blue Ribbon Commission that meets in public and includes all stakeholders, review all aspects of health care, including how to save money.

The bill assumes that transparency in hospital costs, something that federal law currently mandates, will lower costs. But costs will just be shifted to those who can least afford them: employees of the City and its retirees, who will be saddled with increased co-pays and reduced networks, including "tiered" hospitals.

The bill assumes that if a City resident knows the price of a procedure, they will go to the cheapest hospital, but there are many considerations in choosing a hospital. And, of course, when someone has an emergency, they don't have time to shop around.

In short, the bill creates a redundant bureaucracy, is unlikely to accomplish its goals, and

likely will result in increased costs to vulnerable New Yorkers.

We look forward to continuing to work with the Council on health care issues. But, please delay any vote on this bill until you address our concerns.

Thank you, and I ask that my entire written testimony be included in the record of this hearing.

CHAIRPERSON NARCISSE: Thank you.

Next?

LISA YOUNG RUBIN: Good Morning Madam Chairs, Distinguished Members of the Health & Hospitals Committees and the New York City Council.

My name is Lisa Young Rubin and I am a volunteer with the NYC Organization of Public Service Retirees – having retired from the New York City Council. While my colleagues and I support the goals of hospital cost transparency, and ultimately, reduced costs of hospital-based treatment for City Retirees and Employees, we also note herein some of our concerns about the possible outcomes of these endeavors.

These concerns include:

One, the "tiering" of hospital facilities, including clinics, to the possible health risks to

City Retirees and Employees with this "tiering" based on what could be inconclusive and incomplete data.

Two, the compromising of the medical privacy safeguards for City Retirees and Employees in the midst of what could be wide-scale sharing of medical records both inside and outside of City Hall.

And, third, what could be needless duplication of efforts and preemption issues in establishing a new office -- especially in times of City staffing shortages and financial concerns -- to address issues already under federal jurisdiction and that could be addressed by current City offices, including the New York City Council itself.

Due to time constraints, I will submit the balance of my testimony for the Council's records. But, I do just want to emphasize that the "tiering" of hospital facilities would apparently be based solely on perceived costs and not on the actual quality and safety of the care. And, we note that it might be impossible to provide complete and accurate comparison of costs of medical procedures, since each health care consumer has a different medical history and medical needs.

Thank you, and would like to submit my entire testimony for the record. Thank you.

CHAIRPERSON NARCISSE: Thank you, and I appreciate you staying in your time.

We are going to take a break and move to the next room. We will take a five minute break, so that we can make the transfer to the next room. And, those who have come from the other hearing will stay in this room. But, the Health and Hospital Committees will go into the next room.

Thank you for your patience and your understanding.

COMMITTEE COUNSEL: Okay, thank you, everyone, for your patience. We are going to proceed.

I am going to call up Barbara Carress. You can proceed when you are ready, thank you.

BARBARA CARRESS: Thank you for scheduling me in. It feels like a more intimate space, so I am going to be a little bit more informal is that's okay.

I am not going to read my statement. We will submit it in writing.

I will make a couple of arguments and, uh, let me summarize them:

The first is, uh, that the cost of health insurance is directly related to the cost of health care. In the case of the City, for example, health care costs, claims, constitute 90 percent of the premium costs -- of the annual premium costs. The other 10 percent of is administration, taxes, profit -- in the case of Empire, or a margin -- in the case of Emblem.

So, the City health insurance cost is about $7.5 billion and $6.75 billion is the cost of health care. And what drives the cost of health care in New York City is the price of hospitals. So, that was my second point.

My third point is that New York City hospitals are among the most expensive in the country. We have some very reasonably priced hospitals, led by Health + Hospitals Corporation, but also we have three of the 50 most expensive health systems in the country -- NYU, Presbyterian, and Montefiore. And all of our big, private systems pricing is in the upper third of hospital systems across the country. Because New York City is a very expensive place to get health care, on average our health care costs are about 20% above the national average. Our hospital costs are

what drive it. And the data is in my written testimony.

I took a look at the costs of the spending in the City employee health plan -- The Comprehensive Benefit Plan -- which is the plan that 70% of City employees opt in to. And I had data between 2014 and 2018. In that four-year period, the cost... (CROSS-TALK)

COMMITTEE COUNSEL: I am sorry to interrupt... I am sorry to interrupt, but, it seems that we are having an issue with the livestream, and so we are going to have to pause for now until the livestream is up and running, thank you.

BARBARA CARRESS: Should I go on?

COMMITTEE COUNSEL: Not for now, we have to take a pause, thank you.

It is up, sorry about that, you can continue.

BARBARA CARRESS: So, the Comprehensive Benefit Plan increase in that four years, the total cost increased by 32%. Some of that was driven by the fact that the City was hiring. So, there were more employees, so the costs is going to go up, because the number of people goes up. But, principally, it went up because prices went up. The costs for doctor

services went up only 18%, which is pretty reasonable, it is less than inflation and reflecting the increase in the number of people insured.

Spending on hospitals in that four years went up 41% -- the Comprehensive Benefit Plan.

So, prices drive insurance, hospitals drive prices, and there really are not easy ways to contain this. To reduce the City's costs which is ,you know, one of the primary interest, obviously, of the members of this committee. You would have to do one of two things: Either shift more of the costs on to employees, which would be as far as I'm concerned, unconscionable. Or find a way to get prices under control. And that is basically the substance of my testimony. I want to [TIMER CHIMES]...

I would like to comment about two... Many things were said this morning, but one of the... I worked for eight years, I helped run the 32BJ Health Fund. I now teach Health Policy at Baruch. And one of the reasons why the BJ Health Fund knows so much about what it spends on health care is because it gets its own claims. It has... It receives copies of the claims that are incurred by every, single member and

every, single institution or provider -- where they get their care.

The City does not have its own claims, because the City is not self-insured. The City is obligated to follow the rules of the insurance company, because it buys insurance as opposed to be self-insured.

So, if the City really wanted to have the kind of analytic capability that BJ has, it would have to do two things: It would have to hire people who know something about health care, which OMB knows a lot about f money, but I don't think they know a lot about health care. Secondly, they would have to be self-insured and get their claims. And, thirdly, they would have to have a basis of comparison, which is what you guys are offering in this bill, to understand the context of those claims.

CHAIRPERSON NARCISSE: Thank you

COMMITTEE COUNSEL: We will be moving on to our next panel.

And, I apologize in advance if I mispronounce any of this names: Rosemary Ceola Frisoni (sp?), Donald Affeck (sp?), Aurea Mangual, and Neal Frumkin.

You can proceed when you are ready, thank you.

NEAL FRUMKIN: First, I would like to thank the members of the Health and Hospitals Committees for this opportunity to speak to you regarding health care accountability and employee related health costs.

My name is Neal Frumkin, and I am the Vice President of Inter-Union Relations for DC 37 Retirees Association. We represent over 50,000 retired workers. And I am speaking in that capacity today.

The health care system in the US is broken. We pay for more in health care costs than any other industrialized country, yet our health outcomes and life expectancy rank near the bottom of rankings of such countries. In 1960, health care expense as a percentage of GPD, nationally, were 5%. In 2020, it was 19.7% of GDP. These costs are expected to grow by at least 5.1% through 2030. Clearly, this is not sustainable. It is more than just hospital costs, it is the whole health care industry.

The question, nationally, in New York State, and in New York City, is how to rein in these costs. An Office of Health Care Accountability would study employee related health costs. It should also look at what changes are needed in our health care system.

The Retiree Association opposes efforts to either force current or retired City workers to pay a greater share of their health care costs or reduce their access to health care services.

Fifty-four years ago, when I first began working for the City of New York, I, like others, was told I would be compensated with salary and premium-free health insurance. And, later, there was a promise of a pension and continued premium-free health care.

Today, you must ask yourself what must be done to honor that commitment. The answer is *not* to offload costs to the City workforce or retirees.

Earlier, Brother Garrido, of DC 37, spoke of Chicago, so I want to address that.

My daughter works for the city of Chicago. Her health insurance coverage has provisions for tiered hospital coverage. When my grandson was two-months old, she was told he needed urgent, emergency open heart surgery. She was told to take him to a [TIMER CHIMES] hospital that was not in the preferred tier -- for the best chance for his survival. She did; he survived, but she had to pay a hefty surcharge for taking him there. She was able to do that, but we

have to ask what about the others who are not able to bear those costs?

City workers there or here, should not have fear that they will have to make the choice of whether to pay for rent, food, or for the health care they need for themselves and their families.

Imposed co-premiums, tiered coverages, and increases in co-pays are not the answer. We reject an apartheid-modeled system where some can afford high priced, high quality health services while many cannot.

Our suggestion is to stop the outrageous increases in charges for medical, hospital, medical insurance, and pharmaceutical benefits that we count on to sustain our lives.

We will be willing partners in finding solutions to these problems. Thank you.

CHAIRPERSON NARCISSE: Thank you.

AUREA MANGUAL: Good morning, My name is Aurea Mangual, and I am also a retiree from DC 37, Local 371.

I retired in 2015, when I was at work, I hardly ever went to the doctor. Since I retired, I have become ill. I have a cardiac issue. Now, DC 37

Executive Director has spoken over there and previously, and so we have been involved in the issue to stop the privatizing of our Medicare. We have members -- retired members from 372, Local 372, I am not a member of 372, but I speak on their behalf, because I help them with their issues. And, so, those retirees, especially the working ladies and gentleman in the lunch rooms and the school crossing guards, who stand out in the cold in the winter and in summer -- every kind of weather, and breathing the fumes from the cars. And, so, those individuals who are retired from that Local, they don't receive thousand dollars in pensions or even social security, because their jobs are only part-time positions.

We have retirees in our association who are suffering from that impact right now, because of the high costs of medical issues that they may have -- as well as the co-payments.

I am one who had a heart attack. You know? All of a sudden. Never expected it. And I have a stack of bills co-payments [this high], because I don't want to pay those co-payments, they're very high for people to... who are like us on a minimal income to pay co-payments. And they have to travel far to the

hospital. And sometimes you cannot even take the train, because you know the crime is very high in the City, and senior citizens are being attacked all over the place for no apparent reason. And, then, they want to inflict pain on us by privatizing our Medicare -- the MLC and the OLR.

And, so, the mayor, wants to implement or force us into some kind of heath care where we are going to have to pay, each one of us, $191 a month or $194 a month, plus the co-payments. And, if you need a procedure, it is either $50, $100, and then never mind the traveling to do the procedure. Because a lot of people cannot take buses, they cannot take the train [TIMER CHIMES], because they are afraid. I am afraid to take the subways. I was never like that. I was one of the biggest activists that DC 37 had. I never thought in my lifetime that I would be here speaking practically against them, because of the issues and the fact that they want to inflict this pain and injury on us -- the retirees. We don't have an income coming in. Some people... I live alone. Some people have dependents. They have a spouse or they have a significant other. And they have to pay double the amount, plus ,you know, they have other

expenses. My rent is $1,200. I pay my rent with my social security. And I live with the pension that I receive, thank God, from my job. I worked 27 years serving the City under three different borough presidents. And I never complained. I loved my job. I did not want to retire, because I wanted to continue working. But, I made room for other people to come in and work in the City, because of the services that we were going to receive. Now, we find ourselves, crossing the road, afraid, that we are not going to have the medical benefits that we were promised 55 years ago. And, so, when Mr. Garrido spoke today, and he threw all of this billion dollars numbers here a trillion dollars, and the cost of this, is he thinking about the cost that it is going to cost us? We don't have any other income coming in. We are not set for life. Some people retired, 15 to 20 years ago, and they don't receive any kind of money. Some of the ladies that I have helped, are going to the hospital, I am interpreter, they receive $446 a month for pension, and less than a $1,000 in social security.

So, I implore you, whatever bill you will implement, because I know that you have worked...

You serve the people of New York, in your particular districts, think of the retirees, and the retirees who are coming, and the active members. They do not earn all of this money to paying these high costs of medication, hospitals, and whatever else comes with it. Thank you.

CHAIRPERSON NARCISSE: Thank you. Thank you, I appreciate your time.

AUREA MANGUAL: I am speaking to from my soul as a person, and for the people that are silent and they cannot speak -- they are afraid to come. I stopped being afraid, because I got sick. And I need help. I need my medical care. And I think I worked and I paid my dues. Thank you... (CROSS-TALK)

CHAIRPERSON NARCISSE: Thank you. Thank you for your time. Thank you for working for the City of New York.

AUREA MANGUAL: And thank you for your services.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: All right, thank you, we are going to be moving on to our last in-person panel. We will hear from Kevin Mora, Leslie Moran, Kevin Elkins, and Rosa, and I am sorry, I was not able to

understand your last name, so if there is a Rosa in the room, please...

CHAIRPERSON NARCISSE: You may start, thank you.

KEVIN MORA: Good afternoon, council members, thank you for having me here.

My name is Kevin Mora; I am a New York City Resident, and I am the co-founder of Power to the Patients, a nonprofit advocacy group that fights for more affordable, equitable, and an honest health care system across the country.

Our focused efforts include raising awareness that prices are now a patient's right -- thanks to the hospital price transparency rule.

We also support further legislations in cities and states around the country -- such as Intro 844 for New York City.

As an organization, we also remind the federal government of their duty to enforce their own price transparency laws. Which they have unfortunately wholly and shamefully unenforced. And, at the federal level, it is worth pointing out that the roughly 4,600 hospitals that are still not complying with the Federal Transparency Rule -- after two years -- have only fined two of them. It is an unfortunate

and pathetic performance by both HHS and CMS, and this reality fully supports the reason that accountability is needed here at the local level in New York City.

Maybe the federal regulators are overburdened or inadequately prepared, or, let's keep in mind, it is a trillion dollar industry, and potentially somehow they are compromised.

I also do not want to be indistinct, because the gentleman from The Greater New York Hospital Association kept pointing out that the latest reports from CMS were sparkling for hospital price transparency. There was a disclaimer with that report, and I quote, "The results cannot be used to determine compliance with respect to every regulatory requirement, which often necessitates a more detailed analysis and direct interaction with the hospital, as occurs during a comprehensive compliance review."

In short, the report is not a detailed, comprehensive compliance review. And it should not be weighed as such.

I think it is also an interesting litmus test when same gentleman from The Greater New York Hospital Association was asked if he knew the prices

for COVID testing, I believe at Montefiore, he said, No, he hadn't memorized all of the costs at all of the hospitals. If transparency had been adopted here in New York City, he easily could have pointed out how to find that information out. And, trust, it is not easy to discern.

Over the last two years, Power to Patients has worked alongside patients, unions, other advocacy groups, and various publications to fight for transparency in health care. We have created several PSAs, and high level speaking opportunities with well known individuals who wholeheartedly believe in this mission to create transparency in health care. This includes Bronx rapper Fat Joe, Greenwich Village resident Susan Sarandon, famed photographer and Tribeca Resident Soler, Brooklyn-based Grammy nominated singer Valerie June, and several Broadway Theater stars including Academy Award nominated Cynthia Erivo.

We also work with the world famous street artist Shepard Fairey, whose art can be seen in museums and galleries in communities around the world, including here in New York City, where is mural for price

transparency has painted in the Bronx, Queens, and [TIMER CHIMES] Brooklyn by the Tats Cru.

Based on the latest studies by the advocacy group Patients' Rights Advocate, 94% of hospitals in New York State are noncompliant with federal transparency rules. And only one of New York City's hospitals is compliment. New York Presbyterian, Weill Cornell, NYU Langone, NYC Health + Hospitals, Jack D. Weiler, Interfaith Hospitals, Memorial Sloan Kettering, and Lenox Hill -- to name a few -- are all not compliant with the Federal Transparency Rule.

When these hospitals avoid transparency, they perpetuate a rigged system that eliminates consumerism and competition for patients and their families and stifles fair planning and negotiations for unions, employers, and the government.

The health care system in New York City that shuns transparent is a system that is inflated, dishonest, distrusted, and works against the best interests of all the people in our city that rely on its services and procedures for health and survival. Fundamentally, this is a total betrayal of New York residents and everyone who works or visits here.

If any hospitals or hospital associations dares contest their noncompliance rating, I am quite confident that Patient Rights Advocate will walk them through the findings. And I also would bet that they would be willing to do it in a very public forum or setting.

In a free market economy such as ours in the United States, competition is essential for that market to be healthy. Products and services must be compete on consumer choice based on price and/or quality. These two factors must exist or the market doesn't work. By hiding prices, the market for New York City hospitals does not and will not work.

Do not get it twisted, this bill is pro consumer.

CHAIRPERSON NARCISSE: Can you wrap it up, please?

KEVIN MORA: Yes.

I will leave you with these last statements: Without hospital prices upfront, every, single hospital bill is a surprise bill. Partial transparency is not transparency. Much in the same way that partially paying your taxes is not adequate. If you park half your car in a legal spot and half in the crosswalk, you deserve a ticket.

We need full transparency from all hospitals. Do not let the system game you.

Lastly, hospitals may not have ethics when it comes to price transparency, but they have deep pockets. They have influence and a agenda for making money. They will try and mightily to water this bill down.

To the elected officials of New York City, all the way up to Mayor Adams, please do not be compromised on this issue. New York City needs hospital price transparency and accountability in health care. We support bill 844. We must create the Office of Health Care Accountability in New York City. Thank you.

CHAIRPERSON NARCISSE: Thank you.

Which is the hospital that is compliant right now?

KEVIN MORA: The single one?

CHAIRPERSON NARCISSE: Mm-hmm?

KEVIN MORA: I have printed out heroically scaled files of all the hospitals in New York that have been reviewed. And, you can see which ones are compliant, which ones are not, and why and why not.

CHAIRPERSON NARCISSE: All right. Is it many of them? Because you said, one. So, do you want to put it on the record?

KEVIN MORA: Well, I was deferring to Patient Rights Advocate to talk on their files.

CHAIRPERSON NARCISSE: Okay, no problem, thank you. Next?

LESLIE MORAN: My name is Leslie Moran, I am the Senior Vice President of the New York Health Plan Association. We are a statewide trade organization that represents 27 health plans that provide comprehensive health care services to more than 8 million fully insured New Yorkers. Those are people enrolled through their employers, or who buy it on their own, who are in government programs, or enrolled through the exchange. And our members also provide health care services to several million other New Yorkers who are covered by self-insured plans who oversee their own health benefits... (CROSS-TALK)

COMMITTEE COUNSEL: I'm sorry, could you please move closer to the microphone?

LESLIE MORAN: So, our plans also provide services to millions of other New Yorkers who are covered by self-insured plans that oversee their own health

benefits, and that includes many of the numerous unions in the city and in the state.

We are here today to support Council Member Menin's proposal to create the Office of Health Care Accountability. On behalf of our members, we think this is a very important step forward.

As per a previous speaker, health insurance premiums are directly and inextricably tied to the underlying costs of health care. We believe that the creation of Office of Health Care Accountability would be in an important step forward, helping to increase transparency about rising costs, and address the factors that contribute to the grown in health care spending.

Our testimony highlights data that shows health care spending continues to rise and that it is rising because of higher prices -- especially on hospitals. All of this, while utilization is actually going down. So, the prices are going up, but utilization has gone down.

One way that we can start to lower costs is by giving consumers meaningful information about prices -- help them shop for their care that same way that they shop for other goods.

As we have talked about, the Federal Hospital Price Transparency Rule was intended to increase transparency and promote competition in the market and enable patients to compare prices. We will not debate which reports on compliance are more accurate; we would just note that, no, there is not full compliance across the board. And of the transparent information that is out there, a lot of it is not truly transparent, it's actually pretty opaque and very difficult for consumers to understand.

Another factor that contributes to increasing hospital prices, is the anti-competitive behavior and contracting practices that large health systems are able to demand through market leverage. Our testimony cites a number of studies that point to the impact that hospital consolidation has and the ability of hospitals to exercise their market power has on prices.

We have also heard from a number of our members that [TIMER CHIMES] that market denominate hospitals often demand anti-competitive terms in their contracts. We believe this is difficult and is anti-consumer.

As I said, we are here to support Council Member Menin's legislation. We think it will play a vital role reining in out of control hospital costs that exacerbate the challenge that consumers, and employers, and labor unions face in accessing high quality and affordable health care. We would urge that you expand the proposed office's oversight to include the anti-competitive contract provisions that we have outlined in our testimony. The authority to exam hospital pricing and contracting practices would help address barriers to greater competition in the market place -- and also help reduce costs for New Yorkers.

Again, we appreciate the opportunity to offer our comments today. Our industry remains committed to working with you and other policymakers on measures that will temper the factors that are driving increases in health care costs to help insure that every New Yorker has access to high quality, affordable health care. And we look forward to continuing this discussion with you. Thank you.

CHAIRPERSON NARCISSE: Thank you.

Let me ask you, maybe you can clarify something for me.

What are the average profits for the members... for your members?

LESLIE MORAN: Well, many of our members are not-for-profit plans. And I would just point out that every... Insurance premiums are highly regulated by the state, and they have to be actuarially supported. And health plans are required under federal and state legislation and laws, to spend a certain amount of every, single premium dollar directly on health care. It is called the Medical Loss Ratio. In New York State, plans have to spend at least 82¢ of every, single premium dollar on health care. And if they fail to do that, they have to refund it directly to the members or the policy holders.

Plans... When you talk about profits, again, any money a plan might make from investments, is outside of what has to be spent on premium dollars.

CHAIRPERSON NARCISSE: So, you are not so sure of the average profits for your members... (CROSS-TALK)

LESLIE MORAN: I don't have the data on average profit margins, if you will.

CHAIRPERSON NARCISSE: Mm-hmm?

LESLIE MORAN: But, I know many of them are on very thin margins.

CHAIRPERSON NARCISSE: Executive salaries and bonuses?

LESLIE MORAN: We don't track that type of information. We... (CROSS-TALK)

CHAIRPERSON NARCISSE: Can you share it when you have it? Can you send it to us?

LESLIE MORAN: I can try and find some. Most of our plans... I will see what I can find for you, yes.

CHAIRPERSON NARCISSE: What are the reimbursement rates for hospitals?

LESLIE MORAN: reimbursed... (CROSS-TALK)

CHAIRPERSON NARCISSE: Average...

LESLIE MORAN: Pardon me?

CHAIRPERSON NARCISSE: The reimbursement rates.

LESLIE MORAN: They vary, I would think by plan... (CROSS-TALK)

CHAIRPERSON NARCISSE: It varies? [INAUDIBLE] plans?

LESLIE MORAN: I am not sure what you mean by reimbursement rates to hospitals. [INAUDIBLE]... (CROSS-TALK)

CHAIRPERSON NARCISSE: Like, if you have to reimburse a hospital for, let's pick one procedure?

LESLIE MORAN: I'm sorry?

CHAIRPERSON NARCISSE: Can you pick procedure? Something that... A sample that everybody is doing.

LESLIE MORAN: That would vary from plan to plan and hospital to hospital, because those are negotiated between the plans and the hospitals.

CHAIRPERSON NARCISSE: Yes. The reason I am asking that question... Because all morning I have been hearing about colonoscopies for example, or C-sections. So, I just want to have kind of a clear understanding of what is going on. So...

LESLIE MORAN: We would like to have a clear understanding, too. And I think that speaks to the reason we are here, is we believe that there should be greater transparency about what the hospitals are charging for these things.

CHAIRPERSON NARCISSE: Okay, so that is the reason that we are here. For transparency and trying to do... Because it should not be opaque for the [INAUDIBLE] I think you mentioned that for patients [INAUDIBLE] procedures.... (CROSS-TALK)

LESLIE MORAN: Exactly, and health plans are very committed to transparency. And health plans have cost estimators. They are required to be on the

exchange in New York State . And as, has been pointed out, the Federal Transparency Rule applies to health insurers as well. But, even before then, health plans were committed to having information for consumers, so that they could go and get a good estimate of what their coverage would be and what their out-of-pocket responsibilities are. So, plans to have costs estimators, and they encourage all of their consumers to use it to be better shoppers.

CHAIRPERSON NARCISSE: Thank you so much for your time.

KEVIN MORA: I have the answer to your earlier question. The only New York City specific hospital that is compliant is The Brooklyn Medical Center in Brooklyn.

CHAIRPERSON NARCISSE: The Brooklyn Medical Center in Brooklyn? Nice. So, that means everyone else can follow?

KEVIN MORA: That’s right. It is possible.

CHAIRPERSON NARCISSE: Yes. So, thank you for your time, and we appreciate your testimony, thanks.

COMMITTEE COUNSEL: Thank you to this panel. I am going to call up Joseph Telano. You can proceed when you are ready.

JOSEPH TELANO: Thank you to Chair Schulman and Chair Narcisse, and to the Committee on Health and the Committee on Hospitals for the opportunity to provide testimony today. My name is Joseph Telano, and I am the Senior Policy Manager with Primary Care Development Corporation or PCDC. We are a nonprofit and U.S. Treasury-certified community development financial institution (CDFI) founded and located in New York City.

Our mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care.

Primary care remains overburdened and underinvested with many lacking access. Although the NYC H+H offers accessible, non-hospital based primary care services, the uninsured or under insured often put off seeking care for treatable illnesses like diabetes until the must seek more expensive emergency care.

Nationally, primary care accounts for about 35% of health care services overall, but only about five to seven percent of spending. However, primary care investment can directly improve patient outcomes and creates health equity. An increase of just one

primary care provider per 10,000 people can generate 5.5% fewer hospital visits, 11% fewer emergency room department visits, and 7% fewer surgeries.

A study on a patient centered medical home program in Oregon found that for every dollar investment in primary care resulted in $13.00 in savings in other services. For these reasons, PCDC supports the establishment of an Office of Health Care Accountability, and, specifically the provision in the legislation that a requires a report that would include the operating profit margin of major insurance providers. This data would not only fulfill the goal of the better cost transparency, but may be used to understand primary care spending by determining how private insurers are investing their profits.

Additionally, the proposed commission to oversee hospital service pricing should emphasize the important of primary care and the role it plays in lowering overall health care costs and preserving hospital access for those in need of hospital specific services.

Including a focus on primary care would help the commission achieve its goal of promoting financial stability for hospitals and lowering overall costs.

Finally, I want to draw the Council's attention to a series of reports on a searchable dashboard relating to primary care access at every city council district, which is created by PCDC with generous and much appreciated support from this council.

Unfortunately, our research revealed that communities with less access to primary care before the pandemic experienced more COVID related illness and deaths than communities with better access.

Our written testimony includes more details and links to the dashboard, and we would be happy to provide additional information.

We urge policy makers to ensure that spending on primary care preventive services meets the needs of the demands of the communities that they serve, so that people can live healthier lives, and so they need the hospital only for the complex care that they are best suited to provide.

We encourage the members of the Council to reach out any time for more information about primary care

in their districts. Thank you for your time, and I would be happy to answer any questions.

CHAIRPERSON NARCISSE: Thank you for your testimony.

JOSEPH TELANO: Thank you

COMMITTEE COUNSEL: Okay, I am going to call a few names in-person, and if they are not present, then we are going to move on to virtual panelists: Rosemary Ceola Frisoni (sp?), Donald Affeck (sp?), Kevin Elkins, and Rosa Rael (sp?)?

Okay, and at this time, if there is anyone in the room who has not testified, but would like to do so, please fill out an appearance card.

All right seeing no one, we will move on to virtual panels.

Our first virtual panel will be Elisabeth Benjamin, Ilaria Santangelo, and Medha Ghosh.

Elisabeth, you will be first, and please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: You may begin.

ELISABETH BENJAMIN: Hi, how are you all?

It has been a long, long, morning, I would imagine and now afternoon. So, if it has been long for me, it has been even longer for you all.

Thank you for being willing to accept my testimony virtually. I was also testifying at another hearing this afternoon, and I managed to get that done, so it was hard to be in two places at once. So, thank you again for your patience and hanging in there on this really important issue.

I work at the Community Service Society of New York. We have been around for over 175 years trying to improve lives of working New Yorkers. And one of our sort of domains is health care. And that is the division that I head up. And our Health Care Division helps around 100,000 New Yorkers either enroll in health insurance or deal with other access to care issues.

One of the things we have seen in the last couple of years, by running our data, is we have noticed a 64% increase in what we call costs of care cases, but really you might think of as medical debt cases. So, this is where people are having problems getting claims submitted, accessing care, asking for hospital financial assistance, you name it.

We have also done a lot or research on hospitals suing patients. We have actually looked at every, single hospital in the state of New York in all 62 county courts, and have identified that the hospitals have sued over 54,000 patients during the five year span of time between 2015 and 2020. That is a lot of people that got sued. And, we were disappointed that so many people were being sued, because when we did a random poll of those cases, we found that the people who were being sued lived in majority minority zip codes often, and low income communities almost all of the time. And this is completely consistent with the big national data sets. So, something is really going on there with hospital billing and medical debt.

And sort of just working way through accessing care. And we know that from helping our patients directly and from our policy work that I just described.

New York State has elevated health care prices, and our hospital prices are amongst the highest in the country. We have seen a 23% increase between 2015 and 2019 in those prices. And, unfortunately, people of color and immigrants are more likely to be

uninsured, so, of course they're impacted the most by those prices.

This whole conversation... We have a bunch of polling data that I am just going to skip, because I know Medha also has been very patient, and I want to give her a chance to speak.

So, I am just going to just mention that we have polling data. You know, 59% of New York City residents have reported cutting pills -- doing all sorts of measures to kind of hoard their health care recourses, because they can't afford it. Another tranche are living in fear of being sued or having their credit ruined.

So, what can we do? And I guess, I would like to say is that I think this bill is a really good start. And what has been sort of missing from this whole conversation about what Intro 844 would do, is...

SERGEANT AT ARMS: Your time expired.

ELISABETH BENJAMIN: It's... No problem, I have just one more... one more minute.

We really support this bill, and why (sic)?

So, what everybody has been talking about is that you go onto each hospital's website. Well, there's 40 in New York City. No patient can do that. What

Intro 844 would do is set up a central website that everyone could go to where they could then do apples to apples comparisons. Much like the New York's state of health market place. That is what consumers need. They need a price comparison tool between hospitals. It's not helpful... I mean, Council Member Menin was so articulate and talking about, oh, I went through... I, too, have gone through all of the hospitals, individual, you know, price transparency thing. But, even if we had those 300 shoppable events that David Rich was talking about, in a central data base where you could do... Pull down like three or four hospitals as once in your neighborhood and do apples to apples comparisons, what a boon that would be to the patients we serve! And I think that is what we have been missing.

The thing that I would also add to Intro 844, which is not currently in there, that we would love to see, is just some quality measures be compared across hospitals. And, of course, access to hospital financial assistance, which is something that did come up about the community benefits. It is a major component of community benefit obligation, is how

much financial assistance are these hospitals actually supplying.

So, I will stop. I am happy to take questions if anybody has left. But, I also understand that is has been a long day.

CHAIRPERSON NARCISSE: Thank you for testimony.

Any questions?

COMMITTEE COUNSEL: Thank you, we will be moving on to Ilaria Santangelo, please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: You may begin.

ILARIA SANTANGELO: Good afternoon, New York City Council Members. Thank you for the opportunity to testify today about the need to create an Office of Healthcare Accountability in New York City. My name is Ilaria Santangelo, and I am the Director of Research at PatientRightsAdvocate.org, a non-partisan, non-profit organization seeking real prices, real choices, and a functional marketplace in healthcare.

I led the team that created the recent Hospital Price Transparency Compliance Report, which found that only 24.5 percent of hospitals nationwide were fully complying with *every* regulation in the federal

price transparency rule, in effect now over two years. New York hospitals fared worse at 6 percent with major New York City health systems such as New York Presbyterian, New York City Health and Hospitals Corporation, Northwell Health, Mount Sinai, and NYU Langone failing to fully comply.

It is also important to note that CMS published their report and claims, which I quote, "...the results cannot be used to determine compliance with respect to every regulatory requirement, which often necessitates a more detailed analysis and direct interaction with the hospital, as occurs during a comprehensive compliance review." CMS makes it clear that their report is not a detailed, comprehensive compliance review.

Here at PRA, we are transparent about our methodology, which CMS is not. We believe that partial compliance is noncompliance. It is also to note that the Office of the Inspector General is investigating CMS on their enforcement of this rule.

As you know, by law, hospitals must post all prices clearly and completely by payer and plan, including cash prices. Despite what the hospitals say, this is easy. They want you to think it's hard,

and only groups opposed to this bill are from the hospitals and insurance companies.

Only when consumers can compare prices, and see, for instance, that an MRI can cost $300 or $3,000, can they make good purchasing decisions. Fully compliant price transparency would unleash competition, level out price variations, and lower healthcare costs for all patients, employers, unions and workers.

Only when consumers can compare prices, and see, for instance, that an MRI can cost $300 or $3,000, can they make good purchasing decisions. Fully compliant price transparency would unleash competition, level out price variations, and lower healthcare costs for all patients, employers, unions and workers.

I also think this is worth mentioning, and let’s not sugar coat this, estimates do not work. They provide no accountability, and the estimates hospitals are actually providing patients disclaim that it’s not going to be the final price, and they make patients check a box to make sure that they agree. We don’t tolerate this elsewhere. Let’s stop tolerating it in healthcare.

Please vote in favor of this bill. New Yorkers need this. Double down on the federal law and let New York take the lead in revolutionizing healthcare in our country, holding New York City hospitals accountable, and lowering healthcare costs for all New Yorkers. Thank you.

CHAIRPERSON NARCISSE: Thank you for keeping with the time. Thank you for your testimony.

COMMITTEE COUNSEL: Thank you. We will be moving on to Medha Ghosh. Please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: Time starts now.

MEDHA GHOSH: Good afternoon, my name is Medha Ghosh, and I am the Health Policy Coordinator at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Schulman and Chair Narcisse for holding this hearing and providing this opportunity to testify.

Founded in 1986, CACF is the nation’s only pan-Asian children and families’ advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need.

CACF is in support of Council Member Menin's Intro Bill 844 that would establish an Office of Healthcare Accountability. We see a major need for cost transparency of New York City hospitals. Our hope with this bill is that language access will be centered in its implementation. As the bill plans to create a publicly accessible website that provides information on the costs of hospital procedures and summarizes the cost transparency of each hospital, it is important that this site would also be available in a variety of languages so our Limited English Proficient (LEP) patients are able to access it as well. We also hope that cost transparency would also include the costs related to hospitals' usage of translation and interpretation services for LEP patients.

Nearly 19 million people reside in the New York City metropolitan area, and over 800 different languages are spoken. Because of New York City's linguistic diversity, it is incredibly important to ensure language access. Language barriers are a huge obstacle faced by many folks in immigrant communities.

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting health care settings in New York State, we have found that many LEP patients still report facing difficulties like being unable to find an interpreter that speaks their dialect or being unable to fill out paperwork because a translated version in their language does not exist.

While hospitals spend considerable amounts on language services, our research has found that these services often do not meet the needs of LEP patients. There is a need for more accountability and transparency around usage of funding by hospitals towards language services so that language access in healthcare settings can improve.

We hope that language access can be prioritized in the creation of an Office of Healthcare Accountability.

Thank you very much for your time.

CHAIRPERSON NARCISSE: Thank you for your testimony.

COMMITTEE COUNSEL: Thank you very much.

We are going to be moving on to our virtual panel. We are going to have Dr. Vikas Saini, Lola Simpson, and Maria Viera.

Please wait for the Sergeant At Arms to call time. We will start with Dr. Saini.

SERGEANT AT ARMS: You may begin.

DR. SAINI: Hello, thank you, my name is Vikas Saini. I am pleased to be here to support this proposed legislation.

I am president of the Lown Institute, which is a nonpartisan think tank in Boston. We are committed to the creation of a health system that is socially responsible and that works for everyone.

We think American healthcare is at crossroads. When nonprofit hospitals were first established over a century ago, it there was an implicit social contract: communities would invest in hospitals by foregoing tax dollars, and in exchange, hospitals would provide charity care and promote community health.

Now, over these 100 years, American health care has increasingly become a money-driven system. Our research has found that now that nonprofit hospitals too often do not hold up their end of the bargain.

The Lown Institute publishes many metrics of hospital social responsibility. One of these is Fair Share, compares a hospital's spending to direct community health needs and compares that to the tax breaks that hospitals receive. Nation-wide, the majority of nonprofit health systems fall short; last year we found they took in $18 billion more in tax breaks than they spent on charity care.

We recently conducted, on behalf of 32BJ, a more detailed study and reported on New York City's Fair Share deficits, and we found that nine of the 21 non-profit hospitals, including many of the largest and most prestigious, spent less on their communities than they received in tax breaks, resulting in a deficit of $727 million for New York City tax payers in 2019.

Now, $727 million dollars would go a long way to addressing a lot of community health needs , in mental health for example, HIV care, and housing stability. In fact, it would be enough to pay for 7,000 social workers, 30,000 annual doses of HIV drugs, and thousands of affordable homes.

The wide gap between health needs and community investment reflects a fundamental disconnect between

the intent of our laws and their implementation. And, I would say that goes for the IRS rules as well.

Although the Affordable Care Act requires hospitals to assess their community needs, there is no requirement that they link their spending to those needs.

The Fair Share deficits we are reporting are just one of many examples of serious systemic problems in American health care -- too little transparency and no accountability. We have been hearing about it for prices, the same is true for community benefit spending.

New York now has an opportunity to lead the nation in correcting these deficiencies, and so we support the creation of an Office of Health Care Accountability.

We support provisions that would require full and accurate disclosures of hospitals' multiple property parcels -- under many different names -- to improve estimates... (CROSS-TALK)

SERGEANT AT ARMS: Your time has expired.

DR. SAINI: Thank you... Uh, of the tax breaks they enjoy. We also support provisions that would require detailed disclosures of program

implementation to connect hospitals to community benefits spending to specific, well adjudicated, and pressing needs of New Yorkers.

Finally, American health care needs real help in transitioning away from a money-minded system that is has become to one that is affordable, effective, and accountable to the communities it serves.

I have plenty of responses to questions throughout the day. I have been listening since 10:00 A. M., including the percent of charity care, the nature of what should and should not be allowed for community benefits spending. And I am happy to answer any questions you have.

Thank you for your attention.

CHAIRPERSON NARCISSE: Thank you for your testimony. Any questions, Colleagues?

Thank you so much.

COMMITTEE COUNSEL: Thank you, we will be moving on to Lola Simpson. Please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: Your time will begin.

LOLA SIMPSON: Thank you.

Good afternoon, Chair Narcisse and Schulman, and Members of the Committee.

My name is Lola Simpson and I am the CEO of AIRnyc. I am speaking today on Bill 844, in support of vulnerable New Yorkers whom AIRnyc serves.

For more than twenty years, AIRnyc, a small community-based organization now located in the South Bronx, has been serving individuals and families citywide using a Community Health Worker CHW model. We strive to improve equity in healthcare access and social care for underserved people of all ages, races, ethnicities, and faiths who bear the highest burdens of poverty and chronic disease, including asthma, diabetes, COPD, hypertension, and high-risk pregnancy.

Last year, we reached more than 30,000 Bronx residents with education and resources, and provided personalized support to more than 2,000 New Yorkers, helping them to navigate healthcare, insurance, and social care systems.

While providing connections to and coordination of care, health coaching, support for chronic disease management, and social care screenings and referrals, AIRnyc works with community residents primarily comprised of Black and Hispanic New Yorkers who are already marginalized by structural racism and

barriers. The lack of transparency about costs associated with hospital procedures disproportionately impacts the most vulnerable New Yorkers, including AIRnyc's participants. Therefore, we are strongly in support of this bill to establish an Office of Healthcare Accountability that will provide transparency in costs associated with hospital procedures and report on the operating and profit margin of major insurance providers.

Further, our CHWs often find that individuals and families with whom they are working to connect to care -- especially those with multiple chronic diseases requiring hospitalizations, specialty referrals and medical procedures -- forego or postpone recommended care. When asked why, some individuals expressed concern about cost, So, establishing an Office of Accountability would offer transparency on the cost of hospital procedures, and enable our CHWs to help community residents make informed decisions about their care.

AIRnyc believes that a source disclosing information about hospitals' performance in meeting the needs of New York City's underserved communities, including many residents we serve, would

be useful in motivating people to pursue needed care in an appropriate setting. This would be particularly useful for undocumented or uninsured New Yorkers who rely on access to...

SERGEANT AT ARMS: Your time has expired.

LOLA SIMPSON: charity care services. A reliable database of where and how to access a hospital's charity care services would be extremely useful.

In summary, Bill 844 would improve health equity for vulnerable New Yorkers.

Thank you very much for this opportunity to speak on behalf of vulnerable New Yorkers from across the city.

CHAIRPERSON NARCISSE: Thank you for your testimony.

COMMITTEE COUNSEL: Thank you, we will be moving on to Maria Viera. Please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: Time starts now.

MARIA VIERA: Thank you.

Good afternoon, Chair Schulman, Chair Narcisse, and members of the Health Committee.

My name is Maria Viera, I'm VP of Community Affairs at RiseBoro Community Partnership a Local Development Corporation born in Bushwick Brooklyn.

For the past 50 years, RiseBoro has developed over 4,000 units of affordable housing, and has provided critical social services for families and individuals from cradle to grave. RiseBoro employs close to 1,300 individuals, many of whom are human service workers -- which, by the way we are fighting for JustPay.

We believe it's important that the Council understands how rising health care costs, are impacting NYC employers like Riseboro. For many employers that purchase insured products, they may experience rising "insurance" costs, but from our analysis we believe these are largely driven by hospital price increases. Out-of-control hospital prices drive down wages, as they encroach on our fringe rates. Also, they're a significant barrier to accessing affordable healthcare for working people.

According to the report by 32BJ Health Fund, if New York City's hospital pricing and spending patterns matched the rest of the state, it could be

overpaying by as much as $2 billion annually on hospital costs.

We believe the City is over-spending on health care for its employees by $2 billion a year, which cuts into the funding for affordable housing and critical social services that organizations like RiseBoro provide.

Intro 844 will establish an office that will scrutinize and reveal hospital pricing influential variables. If and when a $2 billion overspending is realized, our hope is that the funds are reinvested in healthcare, affordable housing, and social services in communities slighted by disinvestment -- like the neighborhoods where most of our employees reside and our services are provided.

Our vision at RiseBoro is to build a city where your zip code does not determine your health outcomes, housing stability, or economic power. Intro 844 can be a step to help determine those outcomes.

Thank you for the opportunity to speak.

CHAIRPERSON NARCISSE: Thank you for your testimony.

COMMITTEE COUNSEL: Thank you very much. We will be moving on to our last virtual panel.

We will be hearing from David Seltz and Christin Deacon.

David, we will start with you. Please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: You may begin.

DAVID SELTZ: Good afternoon, esteemed members of this committee. It is truly an honor to testify here before you today.

This has just been an incredible hearing. And it is just really reflective of the importance of this issue.

My name is David Seltz, I am the Executive Director of the Massachusetts Health Policy Commission or the HPC as we like to call it.

HPC is an independent state agency that was charged with monitoring health care spending and cost trend in Massachusetts with a stated goal of a more transparent, accountable, equitable health care system that delivers better care, better health at a lower cost for all.

Given some of the similarities between our mission and work and that of the proposed Office of Health Care Accountability in this proposal, I hope

to share a few final thoughts today based on our experience over the past ten years to help inform your deliberation.

In short, we have found that the establishment of a dedicated government office focused on health care costs and enhancing transparency to be a tremendous benefit to policy makers, to workers, to patients, and to the general public.

I would strongly encourage your close consideration of this proposal for the people of New York City.

I bit of background on the HPC, the HPC was established 10 years ago as part of comprehensive legislation really focused on health care costs containment. Our purview is the entire health care system, so all providers and health plans, but we do not regulate pricing. Our tools really are public reporting, public accountability, setting public measurable goals for improvement, and providing data driven policy recommendations.

Like New York City, Boston is home to some of the most prestigious hospitals in the world. And it is a hub for biomedical innovation.

We are also a very expensive health care state. In 2009, Massachusetts was the number one most expensive state in the country on per person health care spending.

This high level of health care costs, combined with high annual increases, resulted in an unsustainable burden on our state and municipal governments, on our businesses -- especially small businesses, and of course on families and individuals -- and especially family and individuals of color and low income.

In response to this challenge, Massachusetts created the HPC and set an annul target for reducing health care spending growth.

So, how have we done? In the past 10 years, Massachusetts spending growth has been below the comparable US average every, single, year. A national study found that Massachusetts had the second lowest rate of growth from 2013 to 2019, and result has been billions saved, billions in building our economy, growing jobs, growing wages. And, now, today, Massachusetts is no longer the most expensive state, we are number three -- but surpassed by Alaska and New York.

So, in closing, I would just like to encourage the Committees consideration... (CROSS-TALK)

SERGEANT AT ARMS: Your time has expired.

DAVID SELTZ: [INAUDIBLE] and I will stand ready as a resource as you move forward with you deliberations.

It has really been an honor, thank you so much.

CHAIRPERSON NARCISSE: Thank you for your testimony.

I am passing into my... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Hi, am Chair Lynn Schulman, and I wanted to ask a question.

Do you have anything in writing that shows the progress that you have made to send to the Council? We would really appreciate it. That would be very helpful.

DAVID SELTZ: Absolutely, I would be happy to, thank you.

CHAIRPERSON NARCISSE: Any questions? Thank you.

COMMITTEE COUNSEL: Thank you.

We are going to be moving on to Christin Deacon.

Please wait for the Sergeant At Arms to call time before you begin your testimony.

SERGEANT AT ARMS: You may begin.

CHRISTIN DEACON: Thank you, good afternoon, honorable council members.

Thank you for the opportunity to speak in favor of Intro 844 today.

I currently work with self-funded health care organizations in New York City and across the county. I am also the former administrator of the state Health Benefits Program for the state of New Jersey where we represented 820,000 public sector workers.

We know that hospitals are essential to the US health care system and the communities that they serve. But, despite this vital role in our communities, the role that some of these hospitals in our economy has shifted in destructive ways. Maximization of revenue rather than the improvement of health is absolutely the standard operating procedure, and is often cloaked by the claim of "No margin, no mission."

Many of those testing before you here today, including myself, have been tasked with managing billions and billions of dollars of worker wages, tax payer dollars, and employer funds. The truth remains that you cannot manage what you don't measure, and you cannot fix what you will not face.

Hospital price transparency, and, indeed, more health care industry transparency, such as the types found in this bill, is really foundational to begin fixing the process.

For the first time, health care purchasers and consumers, will begin to see exactly how and why their money is spent where it is. How is that new glass atrium paid for? Who is paying that multi-million dollar executive salary?

The gentleman from Greater New York Hospital Association made comments regarding the profit margins of insurance carriers -- and, perhaps, this group and suggesting that this group would be better served looking at them when trying to solve this problem. The issue, with all due respect, is that when we self-funded purchasers stood across the table from our carriers and third-party administrators, we are told that hospital prices and anti-competitive contract terms and requirements are the cause of those price increases that occur year over year.

So, which is it? *This* is why we need to see the numbers and make informed decisions instead of guessing and pointing fingers.

The narrative that it is too complex and that we won't understand the data, or we can misinterpret the data is just frankly a transparency tent, pardon the pun, to keep the system opaque and shrouded from the disinfectant of sunshine that is so sorely needed.

Another question was asked that I wanted to address: The honorable councilwoman asked, how the same service, their costs, can vary so widely from hospital to hospital for the same service. But, to take it further, how can the same procedure at the same hospital vary in price depending upon the symbol of your insurance card, or whether even you have an insurance card?

SERGEANT AT ARMS: Your time has expired...

CHRISTIN DEACON: We know...

Finally, I want to address two final points raised by Greater New York Hospital Association, and that is that this bill would be unnecessary because hospitals are already compliant, and that further regulatory burden is a cost too high.

Even though I do not believe this to be the case, if all hospitals were fully compliant, what this bill does is put all of that information into a more usable format for consumers and purchasers.

Moreover, when talking about recourses and labor challenges, I want to highlight a quote that a CEO from one of the largest systems, non-profit, non-compliant, and member of Greater New York made recently when talking about labor challenges. He says, "We are going to come out of this winning. Even if we do have a recession, it doesn't mean that people don't get sick. In fact, people's problems are going to increase, our business will not slow down if we have a recession. It will increase. In the health care sector, even in a recession, the need for hospital services will increase. Leadership to me, is about having a positive disposition, basically saying that whatever happens to you, you are going to win."

What does winning look like to hard working New Yorkers that cannot afford care? What does winning look to the retirees that are forced to come here to you today, because hospitals insist on "winning" at the expense of our citizens?

We are not asking for anything more than transparency so that we can begin to have informed conversations about how to achieve an equitable and just health care system, where the patients and the people have a chance to be the winners.

Thank you

CHAIRPERSON NARCISSE: Thank you for your testimony. I have one question.

You just stated that you can have the same surgery with no extra complications , but different prices? Am I hearing that right?

CHRISTIN DEACON: Absolutely. You can go to the same hospital, uh, have the same procedure, and depending upon the insignia or the symbol on your insurance card, whichever payor, or even if you are uninsured, the rate that you are paying, can be very different.

CHAIRPERSON NARCISSE: Hmm, interesting, interesting.

CHRISTIN DEACON: At the same exact facility.

CHAIRPERSON NARCISSE: Yes, I need facts on that one, because I thought if you have complications, that can justify why the procedure is different. But if it has to do with the insurance card, that is the question.

CHRISTIN DEACON: Yes.

CHAIRPERSON NARCISSE: Thank you. Hold on one second. Any questions?

Okay, no more questions, thank you for your testimony.

CHRISTIN DEACON: Thank you.

CHAIRPERSON NARCISSE: Now, I am going to turn it over Council Member Menin.

COMMITTEE COUNSEL: Thank you, at this time, I am going to read the names of, uh, people who have registered to testify virtually who were not available when we first called their names: Maureen Hensley-Quinn (sp?), Donald Affeck (sp?), and Victoria Veltri?

No? Okay.

And, then, at this time, if there is anyone else who would like to testify virtually, who has not had their name called, please indicate so by using the Zoom Raise Hand Function.

Seeing no hands, turning it back to the chair.

CHAIRPERSON NARCISSE: Thank you, now am turning it over to my colleague, Council Member Julie Menin.

COUNCIL MEMBER MENIN: Thank you so much, I really want to thank you, Chair Narcisse and Chair Schulman for this fantastic hearing. I thought we heard so much compelling testimony, from so many different stakeholders, about why it is important that the

Council acts on the Health Care Accountability and Consumer Protection Act and passes this important piece of legislation. So, I really want to thank you both.

I do want to mention one thing, though, on the record. There were a few people who testified and talked about tiering. And I just want to, for the record, to clarify that this bill has absolutely nothing to do with tiering. It doesn't say anything about tiering. It doesn't relate to tiering. And, on the contrary, knowing more about price creates a healthier and more competitive market for both individuals and for institutions. And counter to some of the testimony we heard about tiering, without more information, we cannot drive down the price, and we cannot really make sure that we are focusing on creating long term affordable coverage that is accessible for all.

So, I just wanted to make sure I correct that misimpression directly on the record.

And we really look forward to continuing the dialogue on this.

Thank you so much.

CHAIRPERSON NARCISSE: Chair Schulman, any closing remarks?

CHAIRPERSON SCHULMAN: I want to second what Council Member Julie Menin said. It was very compelling testimony today. We got a lot of information, heard from a lot of different parties -- including people outside of the state. And ,you know, we are very appreciative of that, and this just shows how great this bill is going to be. And I am looking forward to reducing the costs of health care for New Yorkers, and making sure that everyone, no matter what zip code they live in, has access to affordable health care. Thank you.

CHAIRPERSON NARCISSE: I just want to say thank you. Thank you to everyone who came out to testify. I am Council Member Mercedes Narcisse, Chair of the Committee on Hospitals, but without all of the staff who are doing the work, it would not be possible. So, I want to take a second to say thank you to Christopher Pepe, Senior Legislative Counsel; Sara Sucher, Legislative Counsel, for your time, and thank you; Mahnoor Butt, Legislative Policy Analyst; Danielle Glants, Finance Analyst; Brook Frye, Senior Data Scientist; Crilhien Francisco, Unit Head,

Finance Division; James Wu, Data Scientist; and everyone else who participated to help make it possible.

So, today we had a chance to open the process, open eyes, and we had a lot of questions, a lot of testimony, so I am so appreciative for my colleague. Julie Menin, who keeps on pushing to make sure that we have transparency. We are not here to regulate. We are here for transparency, because we feel, in New York City, we should provide quality health care in every angle of our city. It should be for one group and not the other. And we are still focused on preventive care -- I am a nurse myself. We know the difference preventive care can make, and we want folks to be able to go to the hospital on a regular basis if they have to, and must go for their preventive care. It is cost effective, and we should continue doing that. Health is wealth.

So, I thank you, everyone, for keeping up with us, since 10 o'clock in the morning, we are about to close it out, so if there is nothing else, I am going say, thank you, everyone, and we are going to sign off.

[GAVELING OUT] [GAVEL SOUND]

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 March 15, 2023