NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

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

before the

New York City Council Committees on Health and Hospitals

on

Intro 844

February 23, 2022
City Hall
New York, NY

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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Good morning, Chairs Schulman and Narcisse, and members of the Committees on Health and on Hospitals. I am Dr. Michelle Morse, 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: one, bridging public health and health care, two, advancing the Health Department's commitment to anti-racism in public health practice and policy, and three, which is of 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 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 NYC 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 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 surge, the agency published a report on hospitalizations that identified a 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.

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New York City is one of the most racially segregated health care markets in the United States. This means that our safety-net hospitals and facilities, which include NYC Health and 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 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 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 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 racial essentialism - the belief in innate biological differences between racial groups - but their use also frequently leads to delays in diagnoses, different treatment options, and worse health outcomes among BIPOC patients. 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 undue burden on individuals to shop 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.

New York City Council

Committee on Hospitals
Committee on Health

Testimony by Claire Levitt, Deputy Commissioner,
Mayor's Office of Labor Relations

February 23, 2023

Good morning, Chair Schulman, Chair Narcisse 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. Thank you for this opportunity to discuss Int. 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 with this legislation, 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, about 10% of the entire NYC budget.

The ongoing efforts to address health care costs trace back to the 2014 agreement 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 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 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 those efforts.

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, representing about half of our total health care costs, have doubled. To give some 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 NYS Health Foundation reported that the variation in pricing between NY 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 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 NYC Health + Hospitals, our lowest cost hospital system. 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. However, it should be noted that recently enacted New York State legislation, the Hospital Equity and Affordability Legislation (HEAL) Act, may help to address this issue by barring most-favored-nation provisions and restrictions on disclosure of actual claim costs, prices or quality in certain situations. As we understand, technical corrections to the HEAL Act are moving through the Legislature, and we look forward to the law's implementation.

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 MLC work effectively together in collective

bargaining to set spending levels, design benefits and 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, coded at a lower-case severity than it was. We recover money in all those audits.

The management framework 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 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 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.

New York City Council

Committee on Hospitals | Committee on Health

February 23, 2023

David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy

GREATER NEW YORK HOSPITAL ASSOCIATION

Good morning. My name is David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA). Our members include all New York City hospitals, public and private, as well as hospitals throughout the rest of the State.

Thank you for allowing me to testify today. I hope to clear up some serious misconceptions about hospitals and hospital finances. I also will explain why we believe Intro. 844 directs a new City office to overstep the City's bounds by inappropriately reinterpreting Federal regulations, leading to consumer confusion and false accusations of hospital non-compliance with very complicated Federal regulations.

Intro. 844 would create a new City Office of Healthcare Accountability that would be charged with auditing City spending on health care—which the City Comptroller already does; judge each individual hospital's compliance with the Federal price transparency rule—which the Federal government already does; grade their compliance with the Federal rule using terms not found in the Federal regulation, which a number of advocacy organizations do with quite contradictory results; and opine on the adequacy of community benefits provided by hospitals, potentially disregarding the Federal government's controlling definition of what community benefits are.

The City has no role, and should have no role, in re-interpreting Federal regulations in ways the Federal government never imagined, and grading hospitals using its own interpretations.

The rhetoric surrounding the bill has been unfortunate. As you know, hospitals save lives 24/7, 365 days a year, and are huge economic engines for New York City. Hospitals are trusted and deemed essential by your constituents, and they rate them very high in public opinion polls. Quite simply, accusations of greedy hospitals making enormous profits couldn't be further from the truth.

Our hospitals are struggling financially. A December 2022 survey we conducted with other hospital associations in the State found that 4 out of 5 hospitals reported negative or unsustainable operating margins in 2022. But you do not have to take the hospital associations' word for it. Two highly respected national firms have found the same. Kaufman Hall, a Chicago firm, stated that 2022 "was the worst financial year for hospitals since the start of the COVID-19 pandemic." Fitch Ratings reported that "over the last three years, not-for-profit hospitals have endured multiple disruptions, first from the coronavirus pandemic, and now by labor shortages."

Regarding labor, at a time when hospitals are already struggling, labor costs are exploding due to shortages and the need to increase salaries to retain workers. Below are estimates of the recently ratified nursing settlements in New York City and the expected "ripple-through" impact on other labor costs across New York State. Estimates of the well-documented ripple effect on nursing

personnel and other hospital personnel are arrayed by the percentage of the effect to be experienced, allowing readers to use their judgement as to the full impact.

Table 1. Direct Plus Ripple-Through on Nursing Personnel

$ in Millions	2023	2024	2025	Total
100% Impact	$1,775	$3,033	$4,232	$9,040
75% Impact	$1,404	$2,399	$3,347	$7,150
50% Impact	$1,033	$1,765	$2,462	$5,259
25% Impact	$662	$1,130	$1,577	$3,369

Table 2. Ripple-Through on Other Personnel

$ in Millions	2023	2024	2025	Total
100% Impact	$1,883	$3,610	$5,135	$10,628
75% Impact	$1,412	$2,707	$3,852	$7,971
50% Impact	$941	$1,805	$2,568	$5,314
25% Impact	$471	$902	$1,284	$2,657

The ripple-through to both nursing personnel and non-nursing personnel is inevitable and necessary for hospitals to be able to compete for workers in an extremely tight labor market. This will put added pressure on the bottom-line margins of all hospitals and will mean fiscal calamity for some. Many of you understandably supported the workers in their demands for higher wages. But the bill for these settlements will now come due, so City Council members should consider providing grants—particularly to financially distressed hospitals—to help them afford the settlements you supported.

The rhetoric surrounding the bill also ignores the reality of hospital financing. Concentrating on rates negotiated between insurers and hospitals alone does not come close to telling the whole story.

On average, more than 75% of hospital payments for hospital patient days in New York City are set by the Federal and State governments through Medicare and Medicaid—not "charged" by the hospitals—and hospitals lose money on every Medicare and Medicaid patient they treat. Medicare covers only 85% of the cost of care, and Medicaid is even worse, covering only 61% of costs. No enterprise can survive with such underpayment for their services unless they can negotiate higher payments from private insurers to offset their losses or are subsidized by the State.

In fact, 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 voluntary hospitals in Brooklyn, Queens, the Bronx, and Staten Island, often

referred to as safety net hospitals, have too few privately insured patients to be able to negotiate higher reimbursement rates with commercial insurance companies to offset their Medicaid and Medicare losses, which is why they must get special subsidies from the State. Likewise, NYC Health + Hospitals, the system with the highest proportion of Medicaid-eligible patients, needs extra support that is available to public hospitals through intergovernmental transfers and City subsidies. Medicaid and Medicare rates are simply too low for these hospitals to survive on those payment rates alone. This is why GNYHA and 1199SEIU have been advocating in Albany for increased Medicaid reimbursement rates. I would like to thank Chair Mercedes Narcisse for her advocacy on this as well. It would be great if other members of the Council lent their voices to this cause.

Hospitals with a higher proportion of privately insured patients can try to make up for losses from Medicaid and Medicare by negotiating higher reimbursement rates from commercial 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 hospital—and huge national for-profit insurers have the leverage in New York's competitive hospital marketplace, where eight hospital systems and many freestanding hospitals compete vigorously for patients. The fact that Montefiore Medical Center and UnitedHealthcare were in a dispute that led to Montefiore being out of network for nearly a year shows just how competitive the marketplace is. According to the Health Care Cost Institute, New York City is among the most competitive hospital marketplaces in the nation. This is why there is price variation 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 a huge number of Medicaid-eligible patients. NewYork-Presbyterian provides the most inpatient care to Medicaid-eligible New Yorkers than any other single hospital in the State, followed closely by Montefiore Medical Center, Northwell Health-Long Island Jewish Medical Center, NYU Langone, and Mount Sinai Hospital. This doesn't include the care they provide in ambulatory settings. These enormous losses need to be made up by negotiating higher rates with private insurers.

Proponents of the bill have claimed that if New York City paid hospitals what Medicare pays hospitals, the City would save $2 billion. While I do not know the veracity of that statement, I do know that if all commercial hospital rates devolved to Medicare payment rates, 100% of our hospitals would need subsidies to survive, not just the 12 that are currently receiving them, given that hospitals lose money on every single Medicare patient.

Here are a few reasons we believe the bill is inappropriate and unnecessary.

First, the Federal transparency rule. This rule is appropriately enforced by a Federal agency, the Centers for Medicare & Medicaid Services (CMS). It has two prongs: 1) hospitals must publish on their websites the rates they have negotiated with every health insurer for every service, and 2) publish information on 300 "shoppable services" *or* have a cost estimator on their website. CMS reported just two weeks ago that 82% of hospitals are complying with at least one of the two prongs, 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 non-compliance.

All our hospitals have made good faith efforts to comply with the Federal transparency rule, which is extremely complicated and time consuming. 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.

Despite this, the sponsor of the bill stated on television on Tuesday that only 6% of hospitals are complying. Outside groups have reported that only 25% of hospitals nationwide are compliant, while others have reported that 60% are compliant. Why this discrepancy between the CMS figure of 70% and these estimates? Because groups have taken it upon themselves to interpret CMS's extremely complex rule differently from how CMS interprets and enforces its own rule. This is ridiculous—and we fear the new City Office would do the exact same thing. What criteria would the Office use? Would they follow CMS's guidance and interpretation of their own rule, which would be completely redundant, or make something else up and grade hospitals based on their own interpretations? The Office would have to use its own interpretations because the bill requires the Office to grade hospitals as "very transparent, satisfactory, or not transparent"—concepts that are not contained anywhere in the Federal rule. The only entity that should determine if hospitals are compliant is CMS, period. It is their rule, their requirement, and their enforcement responsibility. It is their rules that hospitals must follow, not a largely undefined new City agency.

Second, the bill would also require the new Office to report on hospitals' compliance with other Federal rules, including Internal Revenue Service (IRS) requirements on the community benefits not-for-profit hospitals must provide and report annually on the IRS's Form 990. The IRS specifically includes in this reporting a variety of community benefits, including charity care; financial assistance policies; community health building activities; education of physicians, nurses, and other health professions for the benefit of the community; losses from caring for Medicaid beneficiaries; and other activities, programs, and expenses.

The outside groups supporting this bill, however, have financed studies by entities that have taken it upon themselves to completely rewrite the IRS's definition of community benefits. They have willy-nilly left out whole categories of community benefits recognized by the IRS. Based on their unauthorized, novel definitions, these groups have deemed hospitals deficient in the community

benefits they provide. Given the biases of the outside proponents of this bill, we fear that this is what the new City Office will do as well.

Third, in addition to being duplicative of Federal and State rules and regulations, the bill focuses almost exclusively on hospitals, as if they are the only part of the health care economy. It virtually ignores behemoth national for-profit health insurance companies such as Elevance (Empire), UnitedHealthcare, and Aetna, all of whom make enormous profits in New York's health care economy and ship those profits out of New York to their parent organizations and shareholders. These profits are gained by delaying and denying payments to hospitals for emergency care for thousands of New Yorkers. It is ludicrous to believe that if somehow hospital payment rates were reduced, these plans would 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 the increasing costs of labor.

In summary, Intro. 844 is inappropriate and unnecessary. I am happy to take any questions you may have.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

New York City Council - Joint Hearing
Committee on Health and the Committee on Hospitals
Thursday, February 23, 2023

NYSNA Testimony in Support of Intro. 844 – Establishing an Office of Healthcare Accountability

Presented by Pat Kane, RN, NYSNA Executive Director

The New York State Nurses Association (NYSNA) represents more than 40,000 registered nurses for collective bargaining across New York State, including more than 9,000 nurses working for the NYC Health + Hospitals public system. We are a leading advocate for universal health coverage for all regardless of ability socio-economic status, racial or ethnic background and ability to pay.

The high cost of providing healthcare coverage for NYSNA nurses working for the NYC Health + Hospitals and various city agency, as well as for our members working in private hospitals around New York City, is an increasingly contentious issue in NYSNA collective bargaining efforts. Our employers increasingly seek to reduce the their healthcare costs by cutting services and shifting more of the costs of care to nurses. These factors played a major role in the strikes that occurred at private hospitals in January of this year and will also be a factor in our current contract talks with the City of New York and NYC Health + Hospitals.

NYSNA strongly supports the proposed legislation, which would amend the City Charter to create an Office of Healthcare Accountability that would be empowered to:

- Make recommendations to the Mayor, Council, Comptroller and city pension trustees regarding healthcare and hospital costs, including the proportion of healthcare costs spent on hospital care;
- Audit City healthcare expenditures for City workers, retirees, and their dependents;
- Maintain an easily accessible and easily understood database showing the comparative cost of hospital procedures/services between different hospitals;
- Provide hospital-by-hospital rankings of price transparency and hospital compliance with disclosure of information rules established by law;

In addition to the public transparency and auditing functions outlined above, the director of the Office of Healthcare Accountability would be required to file an annual public report disclosing the pricing practices of each hospital or hospital system in the City, including:

- A summary of any audits of prices charged to the City of New York for hospital services for employees;
- A summary of the prices charged for each procedure by each hospital and the average rate of reimbursement received the hospital from each insurer or care provider;
- A summary of each hospital's transparency rankings;
- A breakdown of insurance provider or payer profit margins, overhead costs, and executive compensation; and,
- A summary of each hospital's community service plan and the concrete actions taken to provide services addressing local needs and improving access to care, as required by PHL 2803-L.

Hospital costs are now the largest single component in total healthcare expenditures, and in New York make up about 40% of all healthcare spending. In the period 2014 to 2022, New York per-capita health spending grew by 6.1% per year, exceeding national average of growth rates of 4.3%. The escalating costs of healthcare increase total labor costs for public and private employers, and thus become a drag on wages in both the private and public sectors.

Cost pressures have led to an explosion in the number of people, including those with employer provided insurance coverage, delaying or entirely skipping needed care because they cannot afford the out-of-pockets costs. Medical debt continues to be a leading cause of personal bankruptcy, and patients often face abusive collection practices seeking payment of surprise bills from out-of-network services or co-payments that they cannot afford.

The ongoing consolidation of individual hospitals into large hospital systems, combined with their vertical integration of physician practices and other provider services, gives hospital networks inordinate market power and further fuels price increases throughout the healthcare system.

The proposed legislation would create a local mechanism to allow New York City to begin to assert more influence on hospital practices and policies and provide the foundation for greater local input and control over the market practices of hospital systems and protect the provision and availability of needed health services in our communities.

The proposed Office of Healthcare Accountability will give the City more leverage to reduce the rate of growth hospital costs for the City and private employers, allow the City to assess the efficacy of the local tax exemptions provided to the non-profit private hospital systems, and give the City more power to coordinate hospital services to ensure that access, quality of care, and inequities in the healthcare delivery system are effectively addressed.

For these reasons, NYSNA strongly supports the enactment of Intro. 844.

United Federation of Teachers' Testimony
to the New York City Council Committees on Hospitals and Health
on Establishing an Office of Health Care Accountability and Creating an Independent Commission to Oversee Hospital Services Pricing

Feb. 23, 2023

My name is Anne Goldman, and I'm the vice president for non-DOE members of the United Federation of Teachers (UFT) and the head of the Federation of Nurses/UFT. On behalf of the union's more than 190,000 members, I would like to thank the members of the New York City Council's committees on hospitals and health for holding today's public hearing on establishing an office of health care accountability and creating an independent commission to oversee hospital services pricing.

The UFT strongly supports the Council's proposal to establish an office of health care accountability that would review city expenditures on employee-related health care costs, make recommendations on how to lower these costs, create a publicly accessible website that would provide information on the costs of hospital procedures and summarize the cost transparency of each hospital. The office also would report on the factors external to hospitals such as the operating costs and profit margin of major insurance providers. We also strongly support the bill 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 health care costs for New Yorkers.

As the UFT stated when the bill for the independent commission was originally introduced, hospital costs and insurance profits have been black boxes that municipal unions have sought to penetrate with minimal success. We need greater transparency as we fight to keep quality, premium-free health care for city employees. No one should be afraid of transparency if they are doing the right thing by patients.

The UFT has done significant work over the past years to curb hospital billing, including participating in the Coalition for Affordable Hospitals to rein in out of control hospital costs. Research has shown that New York City hospitals charge record rates. A Rand study conducted in 2020 found that NYC hospitals in 2018 charged an average of 302% of the Medicare reimbursement rate for some procedures. Convoluted rules allow NYC hospital systems to raise their prices 6% to 10% every year.

A lack of transparency also kills competition by allowing the largest NYC hospital networks like New York-Presbyterian to charge two to three times more for routine medical services compared with others – for the same quality of care. For example, a normal delivery at New York-Presbyterian in 2018 cost 50% more than a normal delivery at Mount Sinai, Lenox Hill Hospital, North Shore University Hospital and Long Island Jewish Hospital. New York-Presbyterian also charged $83,000 for a hip replacement versus $58,000 at other NYC hospitals. Over the past several years, the cost of a standard hospital admission (with case mix and severity of admission adjusted) has ranged from $12,000 at some NYC hospitals to nearly $36,000 at other NYC hospitals.

Double-digit increases in hospital costs are also fueling a rise in health care costs. The City of New York spent nearly $3 billion on hospital bills for municipal employees in fiscal year 2021, a 50% increase from the $2 billion spent just five years before in 2016. Despite these enormous costs, numerous studies have found that higher hospital pricing does not directly correlate to higher quality care.

Since New York City's health care plan is a self-funded insurance plan that pays hospital claims using city taxpayer dollars, these high rates also mean more money is forked out for claims for the educators and union members we represent, and less funding is available for wage increases and other workplace improvements. The high prices that hospitals charge are hurting working families. Every dollar that goes toward costs is one less dollar that can go to wages for workers and, in the case of government spending, that can be used to fund important public services.

We need more transparency. We need hospitals to disclose information related to pricing when we negotiate our contracts. We need hospitals to stop steering members away from innovative treatments that are often cheaper than traditional procedures. We need to level the playing field so hospitals can't keep demanding double-digit increases every single year and gouging taxpayers and patients for the costs of routine procedures and treatments.

We applaud the City Council for acting on these issues, and we look forward to continuing to work with you to make health care affordable for and accessible to our members and all New Yorkers.

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Testimony of Cora Opsahl, Director, 32BJ Health Fund

New York City Council Hearing

Committee on Health, jointly with the Committee on Hospitals, Bill No. 844

2/23/23

My name is Cora Opsahl, and I am the Director of the 32BJ Health Fund. I am testifying in support of Bill No. 844 to establish an Office of Healthcare Accountability within New York City. 32BJ Health Fund provides health care benefits to over 210,000[1] 32BJ union members and their families. Our members are the front-line workers that keep our buildings in order and airports and schools running!

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, 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, because a recent report showed that less than 10% of NY hospitals are in full compliance with federal transparency laws,[2] 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. For employers that don't have the analytics team that 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.[3] Hospitals account for nearly 40% of all dollars spent on healthcare in New York State, compared to 14% spent on drugs.[4] By contrast we spend about 5% of total operating expenses on our internal overhead and external administration costs.

So hospital prices 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 – 2021 varied from $2,185 at NYC H+H to $10,368 at NYP.[5] We need transparency in hospital pricing, and explanations for the wide differences in price for the same procedures.

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[1] Data from 32BJ Health Fund as of 1/23/23
[2] https://www.patientrightsadvocate.org/february-semi-annual-compliance-report-2023
[3] https://www.32bjhealthfundinsights.org/wp-content/uploads/2022/09/HP-Policy-Practical_print-digital.pdf
[4] Appendix Table e9c in: Emily K. Johnson et al., Varied Health Spending Growth Across US States was Associated With Incomes, Price Levels, and Medicaid Expansion, 2000-19, Health Affairs, 41(8):1088-1097, https://doi.org/10.1377/hlthaff.2021.01834
[5] https://www.32bjhealthfundinsights.org/wp-content/uploads/2022/03/HospitalPrices_online_screen-pages.pdf

Building Service 32BJ Health Fund
25 West 18th Street
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212-388-2000

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.

Committee on Hospitals
Establishing an Office of Healthcare Accountability
AIRnyc Testimony
February 23, 2023 @10:00 AM

Good afternoon, Chair Narcisse and Schulman, and Members of the Committee,

My name is Lola Simpson and I am the CEO of AIRnyc. Prior to leading AIRnyc, I spent over thirty years as a policy and program administrator operating justice-informed, health and human service programs and systems integration in New York City Government and across the country.

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 access and 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 Bill 844 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/or medical procedures--forego or postpone recommended care. When asked why, some individuals expressed concern about cost, among other factors. 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 charity care services. A reliable database of where and how to access a hospital's charity care services would be extremely useful in improving care for the underserved.

In summary, Bill 844 would improve health equity for vulnerable individuals and families, enabling them to access information in advance of services and receive quality care, respectively.

Thank you for this opportunity to speak on behalf of vulnerable New Yorkers from across the city.

AIRnyc| 349 E 149th Street, Ste. 609, Bronx, NY 10451

CENTER FOR INDEPENDENCE OF THE DISABLED, NY

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Testimony to the New York Council Committee on Health and Committee on Hospitals on the following legislation:

- **Int. 844-2022 - a local law to amend the New York city charter, in relation to establishing an office of healthcare accountability.**
- **Int. 912-2023 – a local law in relation to requiring DOHMH to prepare and submit a plan to improve nurse staffing levels at hospitals.**
- **T2023-3046 – resolution calling on NYS 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.**

February 23, 2023

Testimony by:
Heidi Siegfried, Esq.
Director of Health Policy
Center for Independence of the Disabled

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This testimony is submitted on behalf of Center for the Independence of the Disabled, NY (CIDNY), a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence, and equal opportunity for all people with disabilities by removing barriers to full participation in the community. We appreciate the opportunity to share with you our thoughts about these Intros that you are considering.

Because the conditions affecting the individuals and families we represent do not discriminate between rich and poor, we advocate for accessible, affordable, comprehensive and accountable health insurance and care for the privately insured, as well as for those in need of access to public insurance programs. In the past few years, we have turned our attention to pricing, as well as access to coverage and care, because pricing has pushed up the cost of coverage. It has also driven attempts to reduce cost through policies which limit access to care and managed care schemes which deny care and limit access to care.

- **Int. 844-2022 - a local law to amend the New York city charter, in relation to establishing an office of healthcare accountability.**

CIDNY would generally support an Office of Health Care Accountability that would build a publicly accessible website, one that would be accessible to people with visual and other disabilities, that provides information on the cost of hospital procedures, summarizes the cost transparency of each hospital, and reports on factors external to hospitals such as operating and profit margins of major insurance providers as a good first step. It is important to note, however, that providing information to consumers who have relatively little power as individuals has not proved effective at reducing costs. Support for collective action and actual regulations and controls will be needed.

While CIDNY supports the audit of city expenditures on employee-related costs and recommendations on how to lower costs, we would hope that those recommendations would not reduce access to care. This is what we have seen over the last decade or so with New York State's attempts at Medicaid Redesign and, more recently, with New York City's decision to privatize retiree health care. The recommendations also need to be subject to a transparent process that considers the input of those that need the care.

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- **Int. 912-2023 – a local law in relation to requiring DOHMH to prepare and submit a plan to improve nurse staffing levels at hospitals.**

CIDNY has long supported safe staffing legislation for hospitals and nursing facilities. The safe staffing legislation signed into law by the Governor reduced the generally accepted standard for nursing homes residents and its implementation and enforcement has been bumpy. Whatever New York City can do to improve upon safe staffing standards would be most welcome. We do need new strategies to recruit and retain nursing staff.

- **T2023-3046 – resolution calling on NYS 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.**

Governor Hochul announced a Commission on the Future of Health Care in her State of the State address, but the Commission's charge did not include controlling health care prices. This should be a priority for the Commission, and patients and patient advocates should be part of all cost discussions. The State should undertake a serious effort to control hospital and other prices, including strategies like global hospital budgets (as used in Maryland) and rate setting which New York State has done in its past.

Thank you for your consideration of our comments and those of our colleagues.

CACF
Coalition For Asian American Children+Families

New York City Council
Committee on Health jointly with Committee on Hospitals
February 23, 2023

Testimony of Medha Ghosh, MPH, Policy Coordinator
Coalition for Asian American Children and Families (CACF)

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. The Asian American Pacific Islander (AAPI) population comprises nearly 18% of New York City. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the AAPI community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized AAPI New Yorkers. Working with over 70 member and partner organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

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's linguistic diversity, it is incredibly important to ensure language access. Language barriers are a huge obstacle faced by many folks in immigrant communities, and especially in the AAPI community. In New York City, the AAPI community has the highest rate of linguistic isolation of any group, as 46% have limited English proficiency, meaning that they speak English less than very well, according to a recent report from the New York City Department of Health and Mental Hygiene. Moreover, more than 2 in 3 Asian seniors in NYC are LEP, and approximately 49% of all immigrants in NYC are LEP.

CACF

Coalition For Asian American Children+Families

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting healthcare settings in New York, 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. A lack of linguistically accessible services in healthcare settings can have grave consequences: 52% of adverse events that occurred to LEP patients in US hospitals were likely the result of communication errors, and nearly half of these events involved some form of physical harm.

While hospitals spend considerable amounts of 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.

Community Service Society

Powering a more equitable New York

Community Service Society of New York

Testimony before the Committee on Health and the
Committee on Hospitals

February 23, 2023

The Community Service Society of New York (CSS) would like to thank the Committees on Hospitals and the Committee on Health for holding this hearing.

The Community Service Society of New York (CSS) has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable city and state. We power change through a strategic combination of research, services, and advocacy to make New York more livable for people facing economic insecurity. By expanding access to health care, affordable housing, employment, opportunities for individuals with conviction histories, debt assistance, and more, we make a tangible difference in the lives of millions. Our Health Initiatives programs help over 100,000 individuals enroll in and use health coverage annually. Join us at **www.cssny.org**.

Patients Suffer Because of High Health Care Costs

Elevated health care prices affect uninsured and insured New Yorkers alike. New York State has made progress over the past decade in expanding access to health insurance. However, over one million New Yorkers are still uninsured and fully exposed to high health care prices whenever they need medical care. People of color are disproportionately affected by New York's failure to expand health insurance to everyone. Across the State, only 3 percent of White New Yorkers are uninsured compared to 10 percent of Hispanic or Latino New Yorkers, 7 percent of Asian New Yorkers, and 6 percent of Black New Yorkers.[1] Queens and the Bronx have some of the highest proportions of uninsured residents in the State, at 9.3 percent and 7.9 percent respectively. Immigrants likewise are disproportionately uninsured due to immigrant-eligibility prohibitions.

Insurance helps, but it does not provide complete financial protection and many insured people still end with medical debt. The Bureau of Labor Statistic's

[1] Census Table S2701, 2021 five-year estimates.

Personal Consumption Expenditure measure shows that health care spending per person in New York grew 23 percent between 2015 and 2019, even as insurance coverage increased.[2] Only 10 states experienced more spending growth.

In an effort to keep employee contributions steady as premium prices rise, employers have increasingly chosen plans with larger cost-sharing requirements (e.g., deductibles and co-pays). In New York, the average deductible for an employer-sponsored single-person insurance plan more than doubled between 2008 and 2018 ($732 to $1,554).[3] And the combined average employee cost for premiums and deductibles in New York rose 65 percent from 2008 to 2018, from $3,935 to $6,471.[4] Nationally, 25 percent of people with health insurance through their job were underinsured, meaning their out-of-pocket costs are 10 percent or more of their income.[5]

The result of high health care prices are serious for patients:

- 59 percent of New York City residents (nearly all of whom were insured) reported cutting pills, not filling prescriptions, skipping tests or treatments, or not doing what their doctor told them to do because they could not afford to.[6]
- 46 percent percent reported severe financial repercussions due to medical bills, including using up their savings; skipping meals or paying rent; and reported being in collections or having credit card debt. More city residents reported these problems than people in Long Island or the rest of the State.[7]

Further, over 54,000 New Yorkers were sued by hospitals between 2015 and 2020, and there is evidence that these lawsuits disproportionately target low-income patients and people of color.[8]

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[2] 2021 Healthcare Affordability State Policy Scorecard, Altarum Healthcare Value Hub (forthcoming)
[3] Commonwealth Fund, Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, "Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families," Table 4, November 2019, https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.
[4] Commonwealth Fund, Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, "Trends in Employer Health Care Coverage, 2008–2018: Higher Costs for Workers and Their Families," Table 5, November 2019, https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.
[5] Collins et al., "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August 2020, https://www.commonwealthfund.org/sites/default/files/2020-08/Collins_looming_crisis_affordability_biennial_2020_sb.pdf
[6] Altarum Healthcare Value Hub, "New Yorkers Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines," Data Brief No. 37, March 2019, https://www.healthcarevaluehub.org/advocate-resources/publications/new-yorkers-struggle-afford-high-healthcare-costs-support-range-government-solutions-across-party-lines/.
[7] Altarum Healthcare Value Hub, "New York City Boroughs: 59% of Adults Experienced Healthcare Affordability Burdens in the Past Year," Data Brief No. 38, March 2019, https://www.healthcarevaluehub.org/advocate-resources/publications/new-york-city-boroughs-59-adults-experienced-healthcare-affordability-burdens-past-year.
[8] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: Medical Debt and Racial Disparities in Albany County," March 2021, https://www.cssny.org/publications/entry/discharged-into-debt-medical-debt-and-racial-disparities-in-albany-county.

Patients Cannot Control Health Care Prices on Their Own

Even though patients are becoming responsible for more health care direct costs, they have no way to control those costs. Patients do not shop for medical problems; they cannot control when or why they need medical care. When they need medical care, they do not have free choice over which provider they use under most insurance plans. And when they do have more freedom to choose a provider, they often have no information about prices or quality with which to make that type of decision.

Price transparency could help, by providing information to patients who are able to plan ahead for care and by helping insurers reduce premiums. The Centers for Medicare & Medicaid (CMS) require all hospitals to post a list of the prices they have negotiated with insurers and provide a consumer-friendly dashboard showing prices for at least 300 services considered "shoppable" because they can be scheduled ahead of time. However, few of New York City's private hospitals have complied with the rule.[9]

Recommendations

First, the City Council should enact Int 0844-2022, which would create an Office of Healthcare Accountability. This office would audit the city's spending on employee health care and identify opportunities for savings. It would also create a publicly accessible website that provides information on charges for hospital services and monitors hospitals' efforts to increase price transparency. This would help patients who are able to plan ahead for care understand which providers charge the most. It could also help payers, such as the City employee plan, negotiate for better prices, keeping insurance premiums down.

CSS also recommends two other functions for this office. First, it should report on the quality of health care providers. Patient safety and quality of care are an important part of health care provider accountability. The State and several independent organizations track provider quality, but this information is scattered and it is difficult for patients to know which sources they can rely on. The City could perform an important service for the public by vetting and aggregating safety and quality information. Organizing this information alongside costs gives the public a fuller picture of their health care providers.

Second, this office should track how providers treat patients financially. All hospitals in New York State are non-profits who receive billions in federal and State support every year. However, many are not compliant with New York State law or IRS requirements about screening patients for financial assistance before undertaking extraordinary collections activities such as adverse credit reports and lawsuits. Advocates have gathered copious evidence that New York's hospitals are not adequately screening patients for financial assistance—or even informing them

[9] 32BJ Health Fund, "Price Transparency Compliance Among NYC Hospitals," https://www.32bjhealthfundinsights.org/wp-content/uploads/2021/07/32BJ-Health-Fund-Price-Transparency-Compliance-Among-NYC-Hospitals.pdf.

that they have financial assistance policies.[10] Hospitals improved their compliance after the State began auditing them in 2012; however, the most recent audit data shows they are backsliding.[11] Some of the most common problems are clear violations of State law, such as applications that ask for Social Security numbers or past tax returns. The Office of Health Care Accountability could collect or aggregate existing data on the number of patients sued by a provider, the number of patients put into collections, and the amount of patients screened and approved for financial assistance.

Thank you for the opportunity to submit this testimony today. Should you have any questions, please do not hesitate to contact me at: 212-614-5461 or at ebenjamin@cssny.org.

[10] Carrie Tracy, Elisabeth Benjamin, and Amanda Dunker, "Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged," Community Service Society of New York, January 2018, https://www.cssny.org/publications/entry/unintended_consequences.

[11] Health Care For All New York, "Still Waiting After All These Years: Many Nonprofit Hospitals' Financial Aid Policies Fail Health Department Audits," Blog post, November 1, 2021, https://hcfany.org/still-waiting/.

Testimony of Victoria Veltri, JD, LLM
Before the New York City Council
Committees on Health and Hospitals

In Support of Bill 844 to Create an Office of Healthcare Accountability
February 23, 2023

Good morning members of the New York City Council Committees on Health and Hospitals.

I am Vicki Veltri. I am the first and former executive director of the state of Connecticut Office of Health Strategy (OHS). I am here today in my personal capacity.

I am happy to be here to testify concerning Bill 844, to create an Office of Healthcare Accountability, introduced by Council members Menin and Schulman. I applaud the work of the 32BJ Health Fund and other committed partners supporting this bill.

As amended, Bill 844 would create an entity inside of city government responsible for accountability for health care cost growth and outcomes, make recommendations for appropriate benchmarks or targets to measure hospital prices and price growth, and to report annually to officials on healthcare and hospital information that is collected by the new office, including reporting on price transparency compliance.

My testimony today will focus on the importance of setting up such an entity, both for policy reasons and to ensure neutrality and objectiveness, to address specific priorities of New York City, appropriate analytical support and consistency in data collection and reporting.

As amended, this bill aims to create a centralized entity in New York City that will be responsible for:

1) Compiling, understanding, and publishing healthcare and hospital information (e.g., hospital price transparency, Medicare Cost Reports, IRS Form 990s, insurer medical loss ratios)
2) Auditing city employee health plan expenditures, including hospital prices as a portion of total healthcare benefit costs.
3) Submitting an annual report to state officials on the information above, including an analysis of hospital price transparency compliance
4) Making a recommendation for an appropriate benchmark to measure hospital prices and price growth.

The Connecticut Office of Health Strategy, OHS, was fully established in 2018.[1] The impetus for OHS was like that of the proposed Office of Healthcare Accountability. Affordability of healthcare was the driving force in Connecticut for OHS. We brought OHS into being by building will across both sides of the aisle. We had a fundamental agreement that transparency of healthcare data and information is critical to educating the public and building will to address affordability. The office made quick inroads on addressing facility fees, debt collection practices, expanding health coverage, developing a quality scorecard, and creating a Connecticut Healthcare Affordability Index.

[1] Chapter 368dd - Office of Health Strategy (ct.gov)

OHS brought together three streams of work that needed to reside in the same office to ensure one point of accountability and one entity with the capabilities, policy wise and analytically, to view the entire landscape of health care delivery and to have a reputation of capability of analysis and integrity.

Innovation Team

- Large scale delivery and payment reforms
- Benchmark Initiative
- Community Benefits Policy

Data Team

- Working oversight of APCD
- Working oversight of HIE
- Oversight of data integration from hospital data
- REL data collection

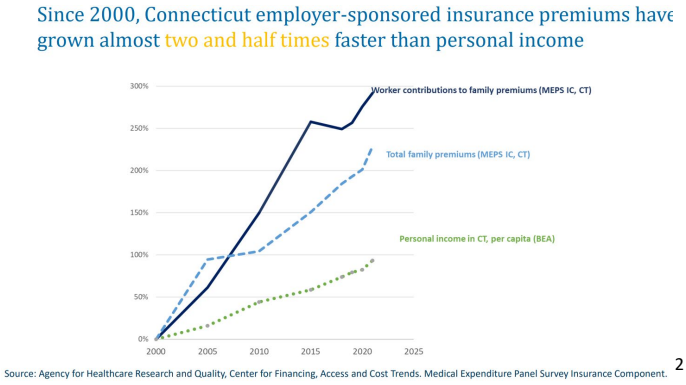
Health Systems Planning

- Certificate of Need
- Cost and Market Impact Review – limited authority
- Hospital and group practice financial and organizational data
- New market study authority

OHS brought together an innovation team, a data team and a hospital and a health system planning team. The health system planning unit pre-existed OHS and was brought into the agency purposely to tie understanding hospital and health system market interactions with other data resources. OHS collects hospital financing reports, including Medicare Cost reports, 990s, and a substantial number of financial filings by hospitals and other providers. Bill 844, as amended, will collect much of this same data. It is imperative that an entity like the proposed OHA have the authority to collect this vital hospital information to ensure not only transparency, but also analysis of the financial information. Understanding health care and hospital financing is critical to understanding issues of affordability and pricing issues affecting every employer and every person. Every year OHS puts out a report with detailed information on hospital financing. OHS's reports, Colorado's recent reports, and reports envisioned in Bill 844 shine a light on what is happening in the hospital and health system arena These reports provide deep insight into cost to charge ratios, payer mix, capital spending, labor costs, administrative expenses, parent system fees, investment income, contractual costs, uncompensated care costs, etc., in other words, factors that contribute directly to prices, utilization, and cost of care.

OHS' detailed hospital reports allowed us to examine community benefits spending by hospitals tied to their tax exemptions. In December 2021, OHS published a report on community benefits spending that made significant recommendations to modify community benefits reporting and implementation strategies. Many of the recommended changes were codified in the next legislative session. Without authority in statute, OHS would not have been able to conduct a critical analysis of community benefit spending tied to Connecticut priorities.

While we looked at hospital financials and action in the marketplace, we knew we needed a way to address overall spending growth while using data to drive decision making. Why? This chart tells the story.



[2]

We followed the leads of Massachusetts, Delaware, and Rhode Island in setting total health care expenditure cost growth benchmarks. We needed to drive entities, hospital systems, health plans, and the state plan itself to growth that would better align with personal income growth. Healthcare cost growth in CT was far outpacing personal income growth and economic growth in the state, an unsustainable trajectory.

We started our benchmarking and reporting efforts on cost growth in 2019 as part of a larger piece of legislation. It was late in session, and though we had the support of both sides of the aisle on this part of the legislation, we did not get the overall bill passed.

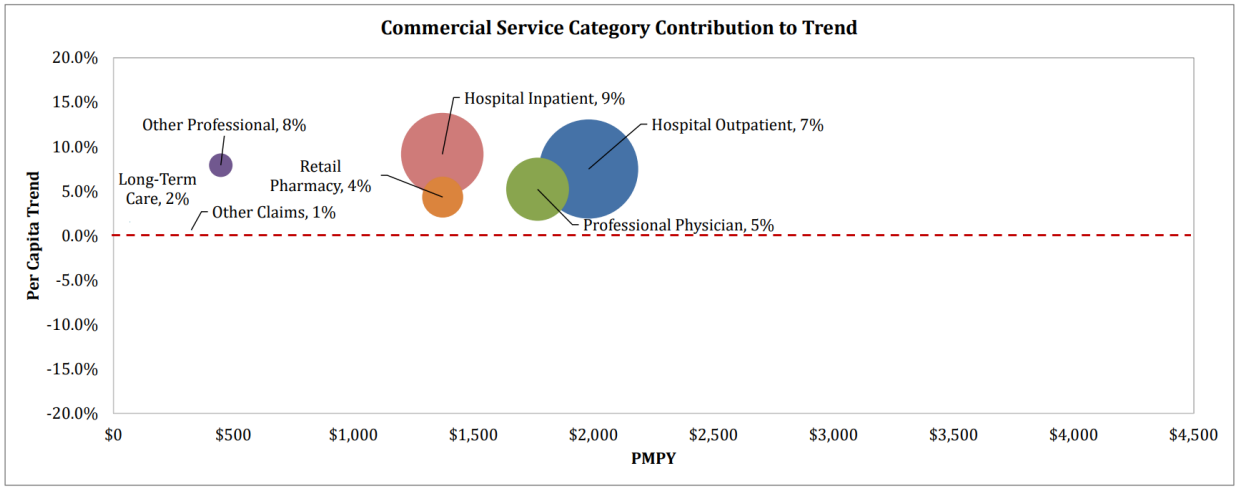
We built a process – meeting with legislators about the importance of transparency in health care spending and collecting data to measure spending growth and utilizing and integrating tools such as our All-Payer Claims Database (APCD) to track variation in utilization patterns and track price growth by sector, payer, and market. We met with employers, purchasers, providers, and unions. We had stakeholder support, including the Moving to Value Alliance, which provided key support. With that support, Governor Lamont signed Executive Order No. 5 in January 2020. The Order allowed us to get our work started on collecting benchmarking data and issuing reports. We secured funds in our budget because this work requires staffing and potential external support. While start-up costs are necessary, spending on start-up would be dwarfed by the impact of containing cost growth and improving affordability. We submitted a governor's bill in the 2020 session, but the session was canceled for COVID, though we had a public hearing and there was significant support for the work.

We applied for and received early support from the Peterson-Milbank Program for Sustainable Health Care Costs and that cemented support for the work. We decided not to codify our bill in 2021 while we worked out the process and made sure we crafted a bill that would work for Connecticut, would continue to get bipartisan support, and would lead to action based on early data submission. We reintroduced a bill in the 2022 session, a Governor's bill. It passed the house by 90 votes and was ultimately included in the budget implementer. The language requires OHS to publicly report on similar topics to Bill 844. It codifies the authority for OHS to set benchmarks for cost growth and primary care spending across all payers, including the state employee health plan, Medicaid, Medicare, and commercial payers. It requires public reporting. It requires analysis of drivers of cost growth, including price variation and price growth.

[2] State of CT, OHS Presentation

Transparency of prices and costs is a critical first step as Bill 844 acknowledges, but the data also collected on prices needs to be credible, and credible data depends on ensuring data reside in a credible entity with accountability to the public that is viewed as objective. OHS is its own agency with its own mission, and that was important in Connecticut. Most states with offices like OHS position healthcare accountability offices in the executive branch, as Bill 844 proposes at the city level.

Hospital Outpatient and Hospital Inpatient Drove Connecticut's Commercial Market Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

OHS CONNECTICUT Office of Health Strategy

Public reporting like that anticipated in Bill 844 can lead to accountability and compliance. It takes the lid off what historically has been a black box of health care. It can make clear what is driving spending, and in Connecticut in 2019 (as shown in the above chart), it was clearly hospital inpatient and outpatient costs that drove commercial spending. Public reporting helps purchasers, including employers, union funds, states, and individuals see what is driving costs and move them to help drive action on these issues.

Transparency is a prerequisite to concrete action. Data can then drive further action. Whether it is action on vertical or horizontal transactions, facility fees, debt practices, out of network reimbursements, price disclosure compliance, medical loss ratios, or other actions, an Office of Healthcare Accountability can help centralize efforts to drive affordability and needed changes in healthcare.

Transparency is not a partisan issue. An Office of Healthcare Accountability in New York City will help you act based on sound data and policy.

Please feel free to reach out to me with any questions at vveltri@comcast.net.

Testimony of Henry Garrido, Executive Director, DC 37
Joint City Council Hearing
Committees on Health and Hospitals
February 23, 2023

Good morning Chairs Schulman and Narcisse and members of the Health and Hospitals Committees of the City Council. My name is Henry Garrido and I am the Executive Director of DC 37, the largest union in the city. I represent 150,000 members and 50,000 retirees. I am here today to support Int. 844, which would establish an Office of Healthcare Accountability. We appreciate CM Julie Menin for sponsoring the bill and Chairs Lynn Schulman and Mercedes Narcisse for holding this hearing bringing this most important issue to light.

For years, hospital prices have steadily increased and, as a result, is now the biggest escalator of hospital costs. In 2021, the federal government passed a law that required hospitals to post their charges, negotiated prices, and cash prices. Unfortunately, much of this data is posted in machine-readable file formats that makes 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 costs 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 profit 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 in 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 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 hospital. These checks and balances in Int. 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 wanted for various procedures. They need to be held accountable for their pricing structures.

It boggles the mind that hospitals are able to charge whatever they want for various procedures. For example, a colonoscopy at NY Presbyterian is $10,368 versus $2,185 at an H+H facility.

Most of these costs for medical costs are cost prohibitive, resulting in patients foregoing much needed procedures. Why should a patient risk their life because they cannot afford a lifesaving procedure? Int. 844 creates an advocate who will aggregate all the information in one place and make it available to patients in a format that is easily accessible and transparent, which will allow patients to make informed decisions and have options to seek treatment elsewhere. Information about actual prices allows patients to avoid overcharging by hospitals in favor of fair market alternatives.

Due to the inflated rates charged by hospitals, these costs have impacted my membership over the years. By creating the Office of Healthcare Accountability, this will empower my members to shop around for the lowest priced services, while fostering competition among hospitals; resulting in lowering healthcare costs overall. We will be able to steer our members to less expensive hospitals, which would save the city money. This would provide the union the ability to negotiate higher wages at a time when our members need a substantial raise to keep up with inflation.

Once again, I want to reiterate my support for Int. 844 and thank the Committees for holding this hearing. I will be happy to take any questions you may have.

Testimony of Bill Hammond

Senior Fellow for Health Policy, Empire Center for Public Policy

To the New York City Council Committee on Hospitals

Regarding Int 0844-2022

February 24, 2023

Hospital care is the single largest driver of health-care costs, yet the industry's pricing policies remain mysterious to the consumers, employers and taxpayers who foot the bill.

The proposed Healthcare Accountability and Consumer Protection Act (Int 0844-2022) would be a breakthrough for transparency in this dysfunctional marketplace, empowering the city and its citizens to avoid being gouged on the expensive services they need for their health and well-being.

The bill would establish an Office of Healthcare Accountability as a new watchdog agency within city government. Its central mission would be to produce consumer-friendly reports comparing prices at city hospitals – based on data gleaned from the city's own health benefit funds as well as other publicly available sources.

This type of information – which is necessary for informed decision-making – is hard to come by now because the contracts between hospitals and insurance companies limit what the parties are allowed to share publicly. Although federal regulations require hospitals to disclose certain pricing information on their websites, the data are often hard to interpret and some institutions are not fully complying.

As New York's largest employer, city government is uniquely positioned to fill this role. It has the right to access and analyze the medical claims data for hundreds of thousands of employees, retirees and family members covered by its health benefit funds – data that would include detailed pricing information for every hospital within city limits and many beyond the five boroughs.

The results of such an analysis are likely to be eye-opening. A recent report by the 32BJ Health Fund – which covers 200,000 unionized building service workers and their families – found striking disparities in the prices charged to its members for common hospital procedures.

For example, the delivery of a baby by Cesarean section typically cost the fund more than $45,000 at NewYork-Presbyterian Hospital, compared to $27,000 at Boston Medical Center and $18,000 at a New York City Health + Hospitals facility.

The proposed Office for Healthcare Accountability could bring more of this type of information to public light – which, at a minimum, would empower the city and its residents to be smarter about shopping for hospital services.

It would also put the public on notice about a major driver of rising health-care costs, which are a growing burden on consumers, employers, taxpayers and the overall economy.

Statewide, New York's per capital health-care spending was the highest among the 50 states in 2020, up from No. 7 at the beginning of the last decade. Rapidly rising hospital costs were the single largest factor, accounting for 46 percent of that growth.

Meanwhile, New York's hospitals receive an average federal quality score of 2.54 out of five stars, the fourth lowest among the 50 states.

New Yorkers deserve more bang for their buck when it comes to hospital care, and shining clearer light on hospital prices is a first step in that direction.

UNITED BROTHERHOOD OF CARPENTERS AND JOINERS OF AMERICA
NEW YORK CITY & VICINITY DISTRICT COUNCIL OF CARPENTERS

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Dear Chair Schulman and Chair Narcisse,

My name is Kevin Elkins and I serve as the Director of Political Action for the New York City & Vicinity District Council of Carpenters. I want to thank the Committees on Health and Hospitals for allowing me to speak on the important issue of rising healthcare costs. On behalf of our 20,000 members who live and work in New York City, I am proud to speak on the importance of the Healthcare Accountability and Consumer Protection Act (Int. 844) and how it will help prevent our members across the City have access to fairer and more accessible healthcare.

The District Council builds this city from the ground up and keeps it running, and our members are highly skilled in everything from concrete form work, metal and wood framing, drywall, flooring, architectural woodwork, roofing and many other skills in between. With such a physical industry, it is crucial construction workers—both union and nonunion—have access to affordable medical care without fear of unnecessary financial burdens. Union membership guarantees our hardworking brothers and sisters have healthcare benefits to keep them strong and healthy throughout their careers and retirement. Nonunion construction workers—who are often times put into unsafe conditions with no protections or inspections—however are three times more likely to lack health insurance at a rate of 24% vs a rate of 7% for all workers in New York. Tragically, the true scope is much worse as it does not take into account the plight of undocumented workers in the industry.

In addition to a massive burden for those with no health care, it also puts a massive strain on city, state, and federal budgets. More than $2 billion a year goes towards providing nonunion construction workers and their families government benefits.

That number will only grow larger since hospital prices are now the single biggest escalator of healthcare costs, and in 2019 accounted for nearly 40 percent of all healthcare spending in New York State.[1] In fact, New York State had the highest per-capita health spending of any state in 2020 ($14,007 compared to a national average of $10,191), and from 2014 to 2020, also had the highest average growth in per-capita healthcare spending, at 6.1 percent per year compared to 4.3 percent nationally.[2] It makes our contract negotiations more difficult and has kept wages low for years. Additionally, high health care costs have

[1] Fraction of Total Personal Health Care Spending on Hospital Services: Appendix Table e9c in: Emily K. Johnson et al., "Varied Health Spending Growth Across US States Was Associated With Incomes, Price Levels, And Medicaid Expansion, 2000–19," Health Affairs, 41(8): 1088–1097, https://doi.org/10.1377/hlthaff.2021.01834

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet#:~:text=Between%202014%20and%202020%2C%20average,growth%20of%204.3%20percent%20nationally

been used by developers as an excuse to deny their workers benefits you and I take for granted, hence that alarming 1 in 4 statistic.

This is where the Healthcare Accountability and Consumer Protection Act comes in. By passing this bill, the City Council has the opportunity to increase transparency for patients seeking medical care and ensure hospitals are not taking advantage of hardworking New Yorkers.

A little data never hurt anyone, except those abusing the system. You can't balance a budget blind, and you shouldn't make major decisions without all the correct information. Yet if we do not pass this bill, that is exactly what New York City is doing.

Let's pass the Healthcare Accountability and Consumer Protection Act. Thank you.

In Solidarity,

Kevin Elkins
Director of Political Action
New York City & Vicinity District Council of Carpenters

Testimony of the New York Health Plan Association

to the

New York City Council Committee on Health and Committee on Hospitals on the subject of

Establishing an Office of Healthcare Accountability

February 23, 2023

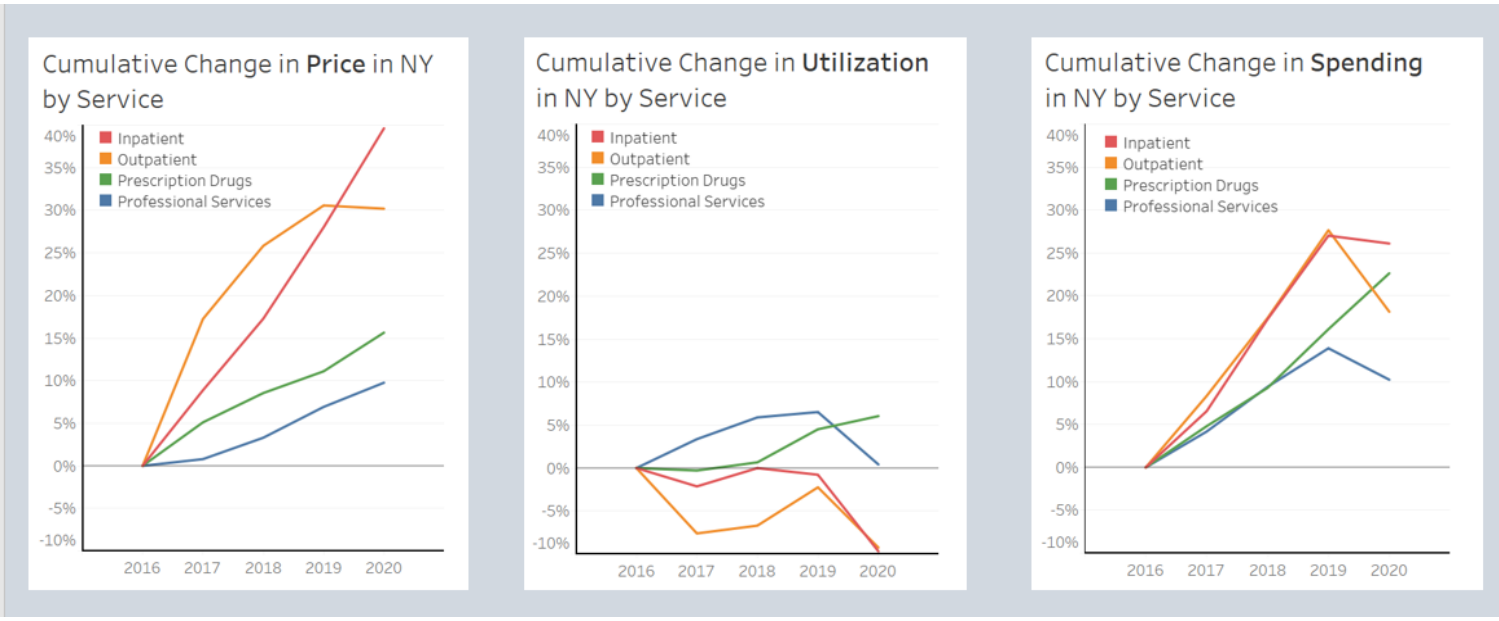
Chair Schulman, Chair Narcisse and members of the committees, thank you for the opportunity to appear at today's hearing on the proposal to create an Office of Healthcare Accountability.

The New York Health Plan Association (HPA) is comprised of 27 health plans that provide comprehensive health care services to more than eight million fully-insured New Yorkers. HPA members include plans that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health plans (PHPs) and managed long term care (MLTC) plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus — and through New York's exchange, the NY State of Health (NYSOH).

We are here today in support of Councilmember Menin's proposal (Int 0844-2022) to create an Office of Healthcare Accountability.

Keeping health care affordable is ***the*** number one challenge facing all of us in the health care system, and rising costs remains the most pressing health care issue facing consumers, employers and working families. The creation of an Office of Healthcare Accountability would be an important step towards increased transparency of rising costs and addressing the factors contributing to the growth in health care spending.

New York's health care costs are among the highest in the country, and markedly higher than the national average. According to the Health Care Cost Institute (HCCI), per person spending in New York is approximately 14% higher than the national average. As the enclosed charts show, increases in spending were directly tied to higher prices – especially on hospitals – while utilization declined.



Source: Health Care Cost Institute (HCCI), Presentation at the HPA 2022 Annual Conference

This is consistent with the 2019 NY State Health Foundation and the Health Care Cost Institute (HCCI) report, *Health Care Spending, Prices and Utilization for Employer-Sponsored Insurance in New York*, which concluded that "spending is increasing at a rapid rate and rising price, not greater utilization of services, is the main culprit."

Increased accountability through meaningful price transparency is necessary to help patients make informed decisions about their care and lower health care costs. While the federal Hospital Price Transparency Rule has been in effect since January 1, 2021, according to a February 6 report by the Patient Rights Advocate, only a quarter of hospitals studied were fully compliant with a federal price transparency rule. For New York, the report showed only 6% are in full compliance. The intention of the Hospital Price Transparency Rule was to enable patients to compare prices and promote competition in the health care markets. However, a recent Kaiser Family Foundation analysis of hospital pricing information found that hospital transparency is very opaque and described some of the data hospitals are sharing as "ambiguous, missing, or difficult to find."

Councilmember Menin's legislation to create an Office of Healthcare Accountability would play a vital role to rein in out-of-control hospital costs and anti-competitive behavior that exacerbate the challenge consumers, employers and labor unions face in accessing high-quality, affordable health care. The bill's provisions to require public reporting on the costs of hospital procedures, annual reporting on hospital pricing practices, and establishing an annual transparency rating for each hospital would help to promote greater accountability to protect New Yorkers.

Government can play an important role to improve the current market dynamics and ensure that hospital pricing and contracting practices do not further impede access and affordability. The Office of Healthcare Accountability would serve as an important safeguard against unchecked price increases large health systems are able to demand through market leverage. A substantial body of research exists to demonstrate that the exercise of market power through consolidation of health care providers into health systems is a primary driver of increased provider prices. A September 2021 issue brief from the Milbank Memorial Fund[1] noted that numerous studies have found "that prices increase between 20% and 60% following the merger of two neighboring hospitals, and researchers have consistently found that physician prices increased by 3% to 14% following an acquisition."

A 2020 report from the Medicare Payment Advisory Commission[2] summarized the literature, stating "[t]aken together, the preponderance of evidence suggests that hospital consolidation leads to higher prices. These findings imply that hospitals seek higher prices from insurers and will get them when they

[1] "Mitigating the Price Impacts of Health Care Provider Consolidation", Katherine L Gudiksen, Alexandra D. Montague, and Jaime S. King, Milbank Memorial Fund Issue Brief, September 2021, https://www.milbank.org/publications/mitigating-the-price-impacts-of-health-care-provider-consolidation/

[2] March 2020 Report to the Congress: Medicare Payment Policy, Congressional request on health care provider consolidation (Chapter 15), http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch15_sec.pdf?sfvrsn=0

have greater bargaining power." Additionally, while advocates of provider mergers often suggest consolidations will result in better integration and improved quality for patients, most studies find no statistically significant impacts on quality after a merger."

Certain provider contracting practices can amplify the impact of provider consolidation, as some health systems have utilized their market power to restrict choice and require use of higher cost alternatives to boost their revenue while increasing health care costs for individuals, families, and employers. As the Milbank brief noted,

> *"many health systems contain at least one must-have provider and may be able to require any insurer wanting to contract with the must-have facility to contract with other facilities controlled by the health system. When using all-or-nothing or affiliate contracting, a health system demands that any health plan that wants to contract with a particular provider or affiliate in a health system must contract with all other providers or a specific affiliated provider in the health system."*

We have heard from our members that market-dominant hospitals often demand anticompetitive terms in their contracts. These include:

- Limiting plan activities that reduce fraud and abuse. For example, hospitals are increasingly demanding health plans eliminate audits that identify cost savings for employer customers. These audits include recovering payments that were also covered by another payer, examining itemized bills before payment to determine if the services are being provided to a plan enrollee, and reviewing claims to validate the principal and secondary diagnoses to ensure all diagnoses were billed appropriately.
- Restricting policies that allow plans' enrollees to choose high-performing, more affordable options to receive care outside of the hospital.

Other examples mirror those cited in the Milbank brief such as:

- "All or nothing" tying arrangements requiring health insurance plans to contract with all of a hospital's general acute care and outpatient services, as well as physician services as a bundle, i.e., take everything together or nothing at all.
- Exclusive dealing requirements in the form of anti-steering and anti-tiering provisions, which prevent insurance companies from steering insureds to less expensive and/or higher quality options as a means to promote competition and reduce prices.

We would urge expanding the oversight of the proposed Office of Healthcare Accountability to include these anticompetitive contract provisions. By having the authority to examine hospital pricing and contracting practices, an Office of Healthcare Accountability would help to address barriers to greater competition in the marketplace and reduce costs for New Yorkers.

Our industry remains committed to working with you and other policymakers on measures to rein in the factors driving increases in the cost of care to ensure that every New York has access to high-quality, affordable health care. We appreciate the opportunity to offer our comments and are happy to engage in further discussions with the Council on this issue.

NYC Council Committees on Health & Hospitals

Joint Committee Hearing:

1)Int. No. 0844-2022 (Establishing a City office of Health Care Accountability), and

2) Preconsidered Resolution No. (for State to create an independent Commission to oversee hospital services pricing)

February 23, 2023

Good Morning Medames Chairs Schulman and Narcisse, Distinguished Members of the Health & Hospitals Committees and the New York City Council, including my Council Member Eric Bottcher:

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:

1. **the "tiering" of hospital facilities**, including clinics, to the possible health risk to City Retirees and Employees with this "tiering" based on what could be inconclusive and incomplete data;
2. **the compromising of the medical privacy safeguards for City Retirees and Employees i**n the midst of what could be wide-scale sharing of medical records both inside and outside of City Hall, and
3. **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.

Thank you.

1) **Tiering of hospital facilities:** This "tiering" of hospital facilities, including clinics that City Retirees and City Employees could use without financial penalty, **would apparently be based solely on perceived costs and not on the actual quality and safety of the care:**

   a) We note that it may be **impossible to provide a complete and accurate comparison of costs of medical procedures, since each health care consumer has a different medical history and medical needs.**

   b) Nonetheless, **this "tiering" could risk the health of City Retirees and Employees as**:

      i). the hospital in the "approved tier" may not necessarily provide **the same quality of care and degree of safety** as compared to the hospital in the "non-approved tier", and

      ii). the hospital in the "approved tier' **may not necessarily employ the doctor or other health care provider whom the**

City Retiree or Employee relies on for his/her/their medical care.

2) **the possible compromising of the medical privacy safeguards for City Retirees City Employees**: Would they have to 'sign away' their rights under the **Health Insurance Portability and Privacy Act (HIPAA) of 1996, the NYS Privacy Law and any related medical privacy laws** as pre-conditions of obtaining or maintaining City health insurance?

a). Who will be in charge - both in the insurers' offices and this new City office - of **ensuring the privacy of City Retirees'/Employees' medical records while they are being audited for hospital/medical expenditures?**

b) What type of expertise will these individuals have so that they can ensure this privacy protection?

c) Is there anyone in the city Office of Labor Relations

with this privacy protection expertise now?

d) **What guarantees would there be that the names and identifying information of the City Retirees/Employees are safely redacted** as files are being shared within and outside of City Hall during these audits?

e) What steps would this new office take to ensure that the City Retirees and Employees are aware of the possible risks to their medical privacy and what steps would be taken to reduce these risks?

f) What steps would this new Office take to notify a City Retiree/Employee if that individual's privacy was breached, and what ameliorative steps would this Office take should this happen?

3) **The risk of inefficiency and incurring federal preemption issues:**

a) Given that the Mayor and the City Council have voiced **concerns**

about staffing shortages and budgetary constraints: Is this the time to establish a new office? It is noted that **there are already City offices - including the City Council – that have sweeping powers under the City Charter to investigate matters of City concern**, including the costs of hospital facilities in the City.

b) Could a court find that this new office is **federally preempted** from enforcing transparency rules that are already required under federal law?

Should the City Council vet the above issues before allowing scarce City resources to be committed to this new city office?

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WRITTEN TESTIMONY FOR HB 844
Ilaria Santangelo
Director of Research

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. Our research 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.' In short, 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. (Also, 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. The only groups opposed to this bill are from the hospitals.

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 it, estimates don't work. They provide no accountability, and the estimates hospitals provide actually disclaim that it will not be the final price. 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.

# # #

Primary Care Development Corporation Testimony
New York City Council
Committee on Health and Committee on Hospitals Joint Hearing
February 23, 2023

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 (PCDC). PCDC is a nonprofit organization and U.S. Treasury-certified community development financial institution (CDFI) founded and located in New York City.

PCDC's mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy. Since our founding in New York City in 1993, PCDC has leveraged more than $1.4 billion to finance over 213 primary care projects. Across the country, these strategic community investments have built the capacity to provide 4.4 million medical visits annually, created or preserved more than 18,585 jobs in low-income communities, and transformed 2.5 million square feet of space into fully functioning primary care and integrated behavioral health practices. In New York State specifically, we have worked with health care organizations, systems, and providers across the state on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services.

I. Primary Care Services Provided by Hospitals

Primary care is the foundation of our health care system and is key to preventing treatable outpatient diseases like diabetes from turning into life threatening conditions. It is the ongoing care that everyone needs in their lives, it keeps people healthy while also saving money, and it's critical to achieving health equity.

Low income, communities of color and other disinvested communities have the least access to primary care and the worst outcomes. Tragically, all New Yorkers saw the effects of this during the height of the COVID pandemic, when communities that had the least access to primary care before the pandemic ended up with the worst outcomes. Since the onset of the pandemic, New York City's neighborhoods with the lowest incomes and lower rates of those insured saw the highest rates of infection and death.[i]

Primary care remains overburdened and underinvested. Many New Yorkers simply lack access to a primary care provider at all. With the number of primary care physicians dwindling nationally, the remaining physicians and practices that do serve low-income, communities of color and other disinvested communities are unable to meet the demand and are facing retirements and burnout in record numbers.

One bright spot in New York City is the NYC Health + Hospitals network, which is committed to being a primary-care centric system, at the same time it is working to provide hospital and emergency services to low income and uninsured New Yorkers. Its NYC Care program is a national model and one that could be replicated by New York's other safety net and voluntary hospitals.

However, many New Yorkers who are under-insured, uninsured or simply cannot access a primary care provider for a variety of reasons often put off seeking care until they must seek emergency care at a

hospital. Many times, these emergency or hospital visits are the results of chronic diseases like heart disease or diabetes that would have been preventable and treatable if the patient had the ability to regularly access a primary care physician.

We urge the Council to ensure that in New York City, primary care and preventative services meet the demands of the communities that they serve, so that people can live healthier lives in more equitable communities and so that they need rely on hospitals only for the tertiary, complex care that hospitals are best suited to provide.

II. Establishing an Office of Healthcare Accountability

PCDC supports the establishment of an Office of Healthcare Accountability and urges both the Committee on Health and the Committee on Hospitals to approve this legislation. The Office of Healthcare Accountability has the potential to help move New York towards a primary care-centered health care system and achieve its goal of creating a clearer understanding on the costs of hospital procedures and building transparency on the costs of each hospital.

We believe that this Office could accomplish several important goals. We particularly wanted to note for the Committees that the provision in this legislation that would require the Office of Healthcare Accountability to issue a report regarding the factors external to hospitals, such as the operating and profit margin of major insurance providers, could be used to determine how private insurers are investing their resources in care.

During last year's state legislative session, the Assembly and Senate passed A7230/S6534, a bill to establish a Primary Care Reform Commission. Although the bill was later vetoed by Governor Hochul, it would have established a commission with some similar goals to the proposed Office of Healthcare Accountability. Specifically, the Commission would have sought similar data from private insurers throughout the state to determine how much money is spent on primary care now and create concrete recommendations for lawmakers about how to increase access to quality primary care through increased spending. The Office of Healthcare Accountability could potentially rely on the private insurer data from their own report to understand primary care spending, as well as fulfil its other goals related to health cost transparency and hospital procedures.

Hospital pricing transparency should include how each hospital prioritizes – or doesn't – primary care services, how much it spends and the proportion of it's spending on primary care, and the types of primary care services and locations that are available to the public.

III. 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.

As the Council considers the legislation to create a commission to oversee hospital service pricing, PCDC urges you to emphasize the importance of primary care services in a potential commission's efforts to increase access to hospital services, promote financial stability for hospitals, and lower healthcare costs for all New Yorkers.

While hospitals do provide primary care, it is not the key service function of their facilities, nor do they appropriately allocate their resources to meet the primary care needs of their patients. PCDC sees the establishment of this commission as an opportunity to emphasize the importance of primary care and how

it can play a huge role in lowering overall healthcare costs while preserving hospital access for those in need of hospital-specific services. Moreover, we saw during the onset of the COVID-19 pandemic that when hospitals are overwhelmed with patients that might have been able to be seen in primary care settings, they are unable to maintain their services for other patients who are in specific need of hospital-level care, such as surgeries.[ii]

There is a strong correlation between primary care access and health care outcomes in a community when it comes to key chronic conditions, as well as a direct relationship between the proportion of spending on primary care and positive community health outcomes. While nationally primary care accounts for about 35 percent of health services overall, only about 5 to 7 percent of spending goes to primary care and experts agree that there is a critical need to increase investment. Both overall spending and reimbursement rates are linked to the supply of primary care providers. Notably Medicaid reimburses at a lower rate as compared to Medicare or private insurance, which has been shown to decrease the number of physicians providing care to Medicaid patients.

However, investing in primary care, both through reimbursement and other investments, can directly improve patient outcomes and increase health equity. For example, an increase of just one primary care provider per 10,000 people can generate 5.5% fewer hospital visits, 11% fewer emergency department visits, and 7% fewer surgeries.[iii] In addition to improving health outcomes, upfront investment in primary care is cost-effective. In one study of a patient-centered medical home program in Oregon, every $1 investment in primary care related to the program resulted in $13 in savings on other services.[iv]

Increasing investment in primary care would not only reduce the burden on hospitals, allowing them more bedspace and capacity to treat other, more seriously ill patients, but would also save the health system money. Further investment and focus on primary care would help the Commission established by this legislation achieve its goal of promoting financial stability for hospitals and lowering overall costs for all New Yorkers.

IV. PCDC's Report on Primary Care Access in NYC Council Districts

With much appreciated support from this Council, PCDC undertook research to identify the relationship between access to primary care and the impact of COVID-19. Unfortunately, but unsurprisingly, our research revealed that communities with less access to primary care before the pandemic experienced more COVID infections and COVID-related illness and deaths than communities with better access to primary care.[v] Our report on this research, *Primary Care Access and Equity in New York's City Council Districts*, was initially released in July 2021. Council members and staff have an opportunity to see their own district's research results by visiting the searchable dashboard with these reports and more data at: https://www.pcdc.org/what-we-do/research/nyc-council-primary-care-access/.

As a result of the pandemic, we have also seen the deferral of necessary health care, which is leading to a crisis of its own and can subsequently put an increased burden on our hospitals. People are now coming back to primary care with more severe preventable diseases, including more advanced cancers, and a drop in childhood vaccinations that could impact children and communities for decades to come.[vi] These lapses might have been prevented if primary care had been included in the initial COVID-19 response.

We encourage members of the Council to reach out at any time for more information about primary care in New York City and in their districts.

V. Conclusion

The data presented in PCDC's research underscores the need for hospitals systems to continue to invest in primary care and ensure that their resources are properly allocated to meet the needs of their patients. While more needs to be done to ensure that every New Yorker has access to a primary care physician in their own community and to ensure an appropriate balance between primary care services and hospital-based services in every community, key elements of these proposed pieces of legislation could help reduce financial burden on individuals, build healthy communities, and save lives.

We welcome the opportunity to work with the Committee on Health, the Committee on Hospitals, and the New York City Council to expand access to primary care for all New Yorkers, particularly for those in disinvested, underserved communities. Please contact Jordan Goldberg, Director of Policy, at jgoldberg@pcdc.org with any questions or to request additional information.

Thank you for your consideration of PCDC's recommendations.

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[i] Zhong X, Zhou Z, Li G, Kwizera MH, Muennig P, Chen Q. Neighborhood disparities in COVID-19 outcomes in New York city over the first two waves of the outbreak. Ann Epidemiol. 2022 Jun;70:45-52. doi: 10.1016/j.annepidem.2022.04.008. Epub 2022 Apr 27. PMID: 35487451; PMCID: PMC9042413.

[ii] Rosenbaum, Lisa. N Engl J Med 2020; 382:2368-2371 DOI: 10.1056/NEJMms2009984 https://www.nejm.org/doi/full/10.1056/NEJMms2009984

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[iv] Gelmon, Sherril, Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. 2016. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf

[v] *See, e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, *available for download at* https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[vi] Dave A. Chokshi & Mitchell H. Katz, *Emerging Lessons From COVID-19 Response in New York City*, JAMA Forum, April 20, 2020, *available at* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2764817.

Maria Viera, RiseBoro Community Partnership
Testimony for NYC HACVA Hearing
2/23/2023

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 4000 units of affordable housing, and has provided critical social services for families and individuals from cradle to grave. RiseBoro employs close to 1300 individuals, many of whom are human service workers (for whom we're 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 NYC's hospital pricing and spending patterns matched the rest of the state, it could be overpaying by as much as $2.0 billion annually on hospital costs. We believe the City is over-spending on health care for its employees by $2B a year, which cuts into the funding for affordable housing and critical social services that organizations like RiseBoro provide. Intro844 will establish an office that will scrutinize and reveal hospital pricing influential variables. If and when a $2B 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 Community Partnership is to build a city where your zip code does not determine your health outcomes, housing stability, or economic power. Intro844 can be a step to help determine those outcomes.

Thank you for the opportunity to speak.

Testimony for the NYC City Council
Committee on Health/Hospitals
February 23, 2023

Hello, I'm Dr. Vikas Saini. Thank you for inviting me to testify today for the committee.

I'm president of the Lown Institute, a nonpartisan think tank in Boston that's committed to the creation of a socially responsible health system that works for everyone. To realize that vision, we all must prioritize three elements: Equity, Quality, and Accountability to communities.

American healthcare is at an historical inflection point. When the nonprofit status of US hospitals was first established over a century ago, it reflected 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 programs.

However, over the years, American healthcare has become increasingly money-driven and our research has found 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 Spending, which compares a hospital's spending on direct community health needs to what it receives in tax breaks.[1] 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 spend on charity care.[2]

We recently published a report that lists Fair Share deficits that are specific to New York City. To make those calculations, we had to search records from multiple sources in order to capture sales taxes, property taxes various holdings, income taxes and the favorable interest rates available for their tax-exempt bond issuances. It took us significant effort to gather all the relevant information in one place. We found that 9 nonprofit hospitals spent less on their communities than they received in tax breaks, resulting in a deficit of $727 million for NYC in 2019.[3]

$727 million dollars is a lot of money. That amount would go a long way toward addressing urgent community needs that hospitals have identified such as mental health, HIV care, and housing stability.[4] In fact, it would be enough to pay for 7,000 social workers, 30,000 yearly doses of HIV drugs, or build thousands of affordable homes.[5]

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[1] The Fair Share Spending metric focuses on categories of community benefit that provide a direct and meaningful benefit to community health. Hospitals provide many public goods like health professions training and research, but not all of these categories are designed to address specific community health needs. See this piece for more on how we measure direct community benefits, and why this distinction is important: https://www.statnews.com/2022/07/07/nonprofit-hospitals-tax-breaks-focus-true-community-aid/

[2] Lown Institute Hospitals Index https://lownhospitalsindex.org/2022-fair-share-spending/

[3] Lown Institute: https://lowninstitute.org/projects/are-nyc-hospitals-earning-their-tax-breaks/

[4] New York Presbyterian Hospital identifies these health issues in their recent Community Health Needs Assessment: https://www.nyp.org/pdf/community-service/NYPH-CHNA-2019-2021.pdf

[5] Cost of PrEP: https://khn.org/news/article/prep-hiv-prevention-costs-covered-problems-insurance/ ; Estimating NY clinical social worker salary at $100,000 (https://www.indeed.com/career/licensed-clinical-social-worker/salaries/New-York--NY) ; According to NYC's Coalition for the Homeless, $2.5 billion in funding would be needed to develop 12,000 new affordable housing units: https://www.coalitionforthehomeless.org/wp-content/uploads/2022/05/Housing-Affordability-Brief_June-2022.pdf

The wide gap between health needs and community investment reflects a fundamental disconnect between the intent of our laws and their implementation. Although the Affordable Care Act requires hospitals to assess their community's health needs, there is *no requirement* that they link their spending to those needs.

The enormous Fair Share Deficits of these hospitals are yet another example of the serious systemic problems in US healthcare–when it comes to measuring how well nonprofit hospitals fulfill their charitable mission, there's very little transparency, and absolutely no accountability. Despite receiving the billions in tax breaks, private nonprofit hospitals *don't spend more* on average than do for-profits on financial assistance to low-income patients.[6] Among nonprofits, hospitals with more financial resources give less charity care proportionately than poorer hospitals.[7] And as large nonprofit hospitals have become big businesses, they have been able to use their power and influence to avoid regulation rather than give back their fair share.

This pattern is familiar: we see the same lack of accountability with regard to price transparency. The low rate of compliance on the federal price transparency rule among NY hospitals, and the high variation in commercial prices are glaring examples.

Another important area to mention is the provision of charity care and care for Medicaid patients. Hospital groups have pointed to the losses they incur by caring for Medicaid patients; however, this burden is shared unequally among hospitals in NYC. The Lown Index includes metrics quantifying hospitals' share of Medicaid patient revenue and provision of charity care, which demonstrates the extent to which they care for low-income and uninsured patients (See supplemental content for a list of these metrics for NYC hospitals).

The Lown Institute believes that having accurate data is a necessary step to accountability. Although we have done a lot with the data we have, there is still much we don't know. We don't know how much the community benefit spending of hospitals is targeted specifically for the most pressing health needs of New Yorkers identified in their health needs assessments. It's also incredibly hard to find the property values of large hospital systems that own parcels under different names, as we learned when we dug into the data. Hospitals don't want the city to have this detailed information, because it would make it much easier to find out how much property tax they are avoiding and calculate their Fair Share Spending.

With this legislation, New York City has an opportunity to be a model for other states and localities of how to increase transparency in the hospital space.

We support the creation of an Office of Healthcare Accountability. We support provisions requiring full and accurate disclosures of hospitals' multiple property parcels under many different names to improve estimates of the tax breaks they enjoy. We also support any provisions that would require detailed disclosures of program implementation to connect hospitals' community benefit spending to specific, well adjudicated, and pressing health needs of New Yorkers.[8] There is a precedent for this latter policy:

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[6] Sources: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01627 ; https://www.wsj.com/articles/nonprofit-hospitals-vs-for-profit-charity-care-spending-11657936777 ; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8481424/

[7] Source: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2760774

[8] Source: https://www.mass.gov/doc/updated-nonprofit-hospital-community-benefits-guidelines/download

Massachusetts' Attorney General already asks hospitals to submit reports on how much they spend to address priority health needs identified in their needs assessments.

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

Thank you.

Supplemental information

Image: Fair Share Spending of 21 private nonprofit hospitals in NYC

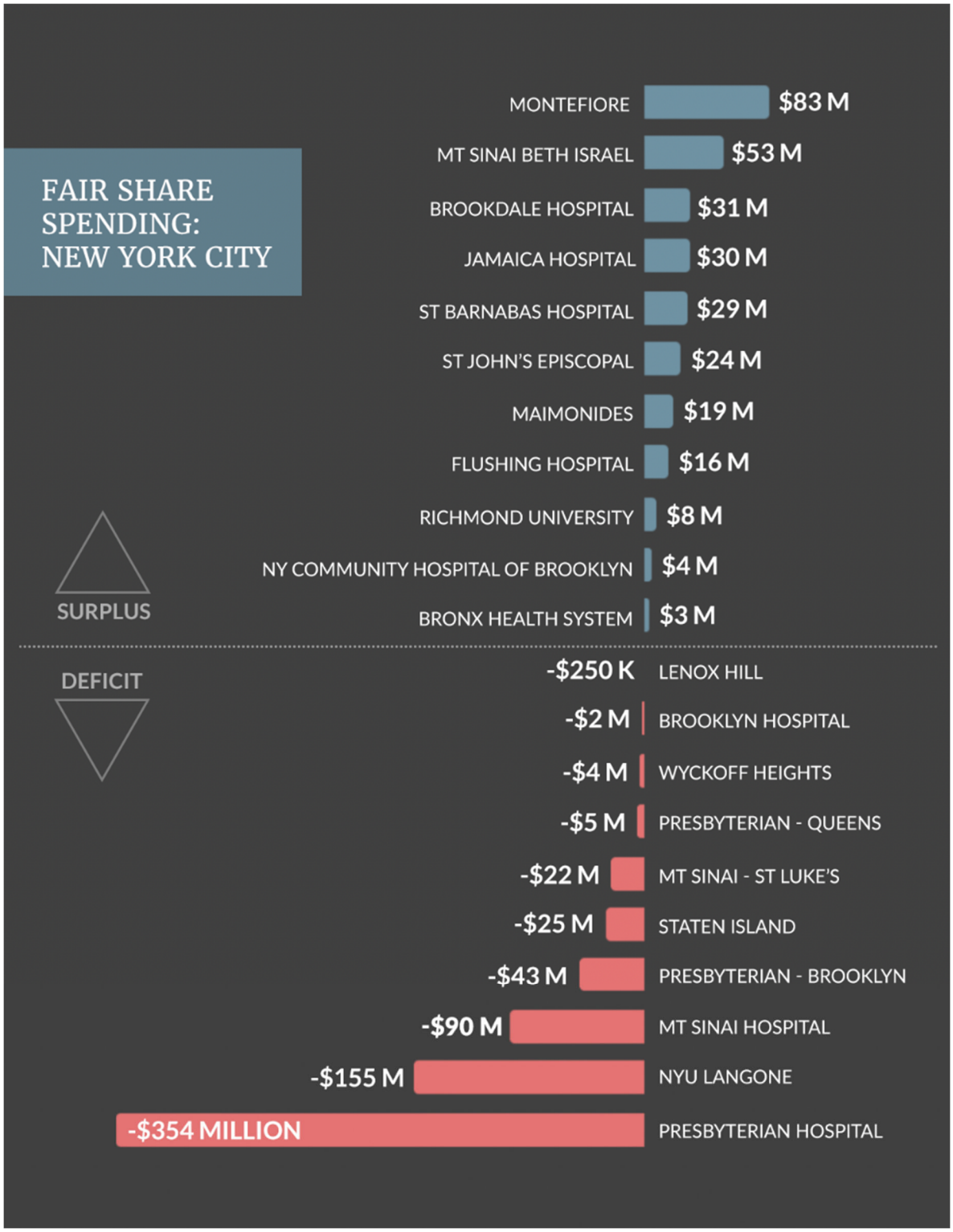

Chart: Hospitals in NYC by their share of Medicaid patient revenue. Source: CMS Hospital Cost Reports, 2019.

Name	City	Medicaid revenue, as share of patient revenue
ST BARNABAS HOSPITAL	BRONX	56.57%
BRONX HEALTH SYSTEM	BRONX	53.55%
SUNY/DOWNSTATE UNIVERSITY HOSPITAL OF BROOKLYN	BROOKLYN	53.44%
FLUSHING HOSPITAL MEDICAL CENTER	FLUSHING	51.92%
WYCKOFF HEIGHTS MEDICAL CENTER	BROOKLYN	49.03%
LINCOLN MEDICAL & MENTAL HEALTH CENTER	BRONX	48.33%
JAMAICA HOSPITAL MEDICAL CENTER	JAMAICA	46.92%
METROPOLITAN HOSPITAL CENTER	NEW YORK	46.81%
WOODHULL MEDICAL & MENTAL HEALTH CENTER	BROOKLYN	46.70%
BELLEVUE HOSPITAL CENTER	NEW YORK	46.57%
NORTH CENTRAL BRONX HOSPITAL	BRONX	46.31%
ELMHURST HOSPITAL CENTER	ELMHURST	45.05%
HARLEM HOSPITAL CENTER	NEW YORK	44.99%
KINGS COUNTY HOSPITAL CENTER	BROOKLYN	42.65%
QUEENS HOSPITAL CENTER	JAMAICA	42.31%
JACOBI MEDICAL CENTER	BRONX	41.07%
ST JOHN'S EPISCOPAL HOSPITAL AT SOUTH SHORE	FAR ROCKAWAY	40.75%
BROOKDALE HOSPITAL MEDICAL CENTER	BROOKLYN	39.62%
NASSAU UNIVERSITY MEDICAL CENTER	EAST MEADOW	38.78%

BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	BROOKLYN	38.13%
MAIMONIDES MEDICAL CENTER	BROOKLYN	37.61%
NYC HEALTH + HOSPITALS/CONEY ISLAND	BROOKLYN	36.64%
MONTEFIORE MEDICAL CENTER	BRONX	35.42%
RICHMOND UNIVERSITY MEDICAL CENTER	STATEN ISLAND	33.99%
NEW YORK-PRESBYTERIAN/QUEENS	FLUSHING	28.75%
MOUNT SINAI ST LUKE'S ROOSEVELT HOSPITAL	NEW YORK	28.38%
MOUNT SINAI BETH ISRAEL	NEW YORK	28.08%
MOUNT SINAI HOSPITAL	NEW YORK	27.79%
LONG ISLAND JEWISH MEDICAL CENTER	NEW HYDE PARK	26.21%
NEW YORK-PRESBYTERIAN/BROOKLYN METHODIST HOSPITAL	BROOKLYN	25.03%
MONTEFIORE NEW ROCHELLE HOSPITAL	NEW ROCHELLE	24.54%
NEW YORK-PRESBYTERIAN HOSPITAL	NEW YORK	24.24%
MERCY MEDICAL CENTER	ROCKVILLE CENTRE	24.05%
STATEN ISLAND UNIVERSITY HOSPITAL	STATEN ISLAND	22.28%
NS/LIJ HS SOUTHSIDE HOSPITAL	BAY SHORE	20.76%
SUNY/STONY BROOK UNIVERSITY HOSPITAL	STONY BROOK	18.38%
LONG ISLAND COMMUNITY HOSPITAL	PATCHOGUE	18.12%
NEW YORK UNIVERSITY LANGONE MEDICAL CENTER	NEW YORK	17.52%
NEW YORK COMMUNITY HOSPITAL OF BROOKLYN, INC.	BROOKLYN	17.14%
MOUNT SINAI SOUTH NASSAU	OCEANSIDE	16.83%

ST CHARLES HOSPITAL	PORT JEFFERSON	16.62%
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	WEST ISLIP	16.52%
PECONIC BAY MEDICAL CENTER	RIVERHEAD	14.91%
LENOX HILL HOSPITAL	NEW YORK	14.86%
NS/LIJ HS HUNTINGTON HOSPITAL	HUNTINGTON	13.41%
NORTH SHORE UNIVERSITY HOSPITAL	MANHASSET	12.69%
NORTHWELL HOSPITAL GLEN COVE	GLEN COVE	12.27%
CHSLI ST JOSEPH HOSPITAL	BETHPAGE	11.41%
ST CATHERINE OF SIENA HOSPITAL	SMITHTOWN	10.98%
JOHN T MATHER MEMORIAL HOSPITAL OF PORT JEFFERSON	PORT JEFFERSON	8.88%
PLAINVIEW HOSPITAL	PLAINVIEW	8.05%
ST FRANCIS HOSPITAL - THE HEART CENTER	ROSLYN	4.57%

Chart: Hospitals in NYC by charity care as a share of total expenses. Source: CMS Hospital Cost Reports, 2019.

Name	City	Charity care as share of total expenses
QUEENS HOSPITAL CENTER	JAMAICA	15.8%
ELMHURST HOSPITAL CENTER	ELMHURST	12.9%
NYC HEALTH + HOSPITALS/CONEY ISLAND	BROOKLYN	11.1%
BELLEVUE HOSPITAL CENTER	NEW YORK	10.6%
WOODHULL MEDICAL & MENTAL HEALTH CENTER	BROOKLYN	8.4%
METROPOLITAN HOSPITAL CENTER	NEW YORK	7.7%
LINCOLN MEDICAL & MENTAL HEALTH CENTER	BRONX	6.6%
KINGS COUNTY HOSPITAL CENTER	BROOKLYN	5.2%
NORTH CENTRAL BRONX HOSPITAL	BRONX	5.2%
JACOBI MEDICAL CENTER	BRONX	5.1%
BRONX HEALTH SYSTEM	BRONX	4.9%
HARLEM HOSPITAL CENTER	NEW YORK	4.8%
NORTHWELL HOSPITAL GLEN COVE	GLEN COVE	3.0%
FLUSHING HOSPITAL MEDICAL CENTER	FLUSHING	2.9%
ST BARNABAS HOSPITAL	BRONX	2.6%
JAMAICA HOSPITAL MEDICAL CENTER	JAMAICA	2.5%
BROOKDALE HOSPITAL MEDICAL CENTER	BROOKLYN	2.4%
CHSLI ST JOSEPH HOSPITAL	BETHPAGE	2.3%
NASSAU UNIVERSITY MEDICAL CENTER	EAST MEADOW	2.0%

MERCY MEDICAL CENTER	ROCKVILLE CENTRE	2.0%
NS/LIJ HS SOUTHSIDE HOSPITAL	BAY SHORE	1.9%
MOUNT SINAI ST LUKE'S ROOSEVELT HOSPITAL	NEW YORK	1.8%
MONTEFIORE NEW ROCHELLE HOSPITAL	NEW ROCHELLE	1.8%
RICHMOND UNIVERSITY MEDICAL CENTER	STATEN ISLAND	1.6%
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	WEST ISLIP	1.6%
MOUNT SINAI BETH ISRAEL	NEW YORK	1.5%
PLAINVIEW HOSPITAL	PLAINVIEW	1.5%
MAIMONIDES MEDICAL CENTER	BROOKLYN	1.5%
STATEN ISLAND UNIVERSITY HOSPITAL	STATEN ISLAND	1.5%
LENOX HILL HOSPITAL	NEW YORK	1.5%
NEW YORK UNIVERSITY LANGONE MEDICAL CENTER	NEW YORK	1.2%
LONG ISLAND JEWISH MEDICAL CENTER	NEW HYDE PARK	1.2%
NEW YORK-PRESBYTERIAN/BROOKLYN METHODIST HOSPITAL	BROOKLYN	1.2%
ST FRANCIS HOSPITAL - THE HEART CENTER	ROSLYN	1.1%
NEW YORK-PRESBYTERIAN/QUEENS	FLUSHING	1.0%
WYCKOFF HEIGHTS MEDICAL CENTER	BROOKLYN	1.0%
ST CATHERINE OF SIENA HOSPITAL	SMITHTOWN	1.0%
LONG ISLAND COMMUNITY HOSPITAL	PATCHOGUE	1.0%
MOUNT SINAI HOSPITAL	NEW YORK	0.9%
MONTEFIORE MEDICAL CENTER	BRONX	0.9%
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	BROOKLYN	0.9%

NORTH SHORE UNIVERSITY HOSPITAL	MANHASSET	0.8%
ST CHARLES HOSPITAL	PORT JEFFERSON	0.8%
ST JOHN'S EPISCOPAL HOSPITAL AT SOUTH SHORE	FAR ROCKAWAY	0.7%
NEW YORK-PRESBYTERIAN HOSPITAL	NEW YORK	0.7%
NS/LIJ HS HUNTINGTON HOSPITAL	HUNTINGTON	0.7%
SUNY/STONY BROOK UNIVERSITY HOSPITAL	STONY BROOK	0.6%
MOUNT SINAI SOUTH NASSAU	OCEANSIDE	0.3%
SUNY/DOWNSTATE UNIVERSITY HOSPITAL OF BROOKLYN	BROOKLYN	0.3%
JOHN T MATHER MEMORIAL HOSPITAL OF PORT JEFFERSON	PORT JEFFERSON	0.2%
NEW YORK COMMUNITY HOSPITAL OF BROOKLYN, INC.	BROOKLYN	0.1%

Written Testimony For **Intro 637**, **Intro 714**, **Intro 196** and **Resolution 38**

FOR THE RECORD

Good Morning, my name is Alexander Marte and I am here today on behalf of Gilbane Development Company. As a member of NYSAFAH, New York's largest affordable housing industry group with over 400 members that include for-profit and nonprofit members, we strongly oppose the legislation being discussed today. Limiting the pool of companies that can apply for RFPs to build on city owned land would only hinder the production capacity of the City of New York to meet the current affordable housing crisis.

We would like to see legislation and/or agency-level policies that would bolster nonprofits capacity to compete in the market, drive innovation and partnerships with for-profit firms including many up-and-coming M/WBE firms, and look at reducing regulatory process, policies, and practices that elongate the timeline for building affordable housing.

We support and would love to see the City continue to invest in the human resources at the various housing agencies as well as increasing the amount of capital that will help non-profits increase their capacity and ability to produce more housing. Such things like increasing funding for the New York Acquisition Fund, Pillars program, and other preservation fund programs as well as continuing to implement its current RFP policy of requiring non-profit and M/WBE participation will help the entire affordable housing ecosystem to create more units, more efficiently. Thank you very much for the opportunity to testify this morning.

Testimony before the New York City Council, Joint Council hearing

Committee on Hospitals, Committee on Health

February 23, 2023

Re: Int. No. 844

Good morning. Thank you chairs Menin and Schulman for the opportunity to testify here today.

I am Barbara Caress. I teach health policy at Baruch. I am a proud member of the PSC and have been working with the Union around City employee health benefits issues and the proposal to impose Medicare Advantage on retirees.

Why is health insurance so expensive? In a few words, health insurance costs so much because health care prices are so high.

About $6.75 billion of $7.5 billion the City pays to health insurance companies is payments to hospitals, doctors, labs, and other providers of medical services. Administration, taxes, and profit (Empire) or margin (Emblem) account for the remaining 10%.

Twenty years ago, a group of prominent health care economists set out to discover why US health spending was so much greater than in other rich countries. At the time most measures of utilization such as physician visits and hospital stays were below the OECD median. There was no evidence that Americans were sicker or that our health care was superior. That left just one possibility. As the authors wrote, "It's the prices, stupid."[1] In 2019 after the death of the senior economist, the same group looked again at the question. Their conclusion, "It's still the prices, stupid."[2]

According to the experts there are many culprits for high prices. Cited most often are the lack of regulation and the absence of effective competition. Put most simply, prices are so high because they can be. For the most part, health care providers and purveyors can get away with high and increasing prices because we consider their products essential and appear willing to pay almost any price.

We can no longer rely on charitable impulses and good will to create reasonable prices – especially here. New York is an expensive place to get health care. The non-profit Health Care Cost Institute calculated the details, "per-person spending on health care services in New York, NY was $5,855, 20 percent above the national median in 2020."[3] Our doctors charge a lot more than average and some of our hospitals are off the charts.

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[1] G. Anderson et al "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." https://www.healthaffairs.org/doi/10.1377/hlthaff.22.3.89

[2] G. Anderson et al "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt" https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144

[3] https://healthcostinstitute.org/hcci-originals/hci-interactive#HMI Summary-Report-Current-Spending

New York's major nonprofit health systems are among the costliest in the country. Medicare prices are the yardstick because its rates are set to reimburse hospitals slightly below full cost – slightly lower to encourage hospitals to be more efficient. Using that benchmark, three of the large systems are among the country's most costly. All NYC private systems rank in the top third of the 311 systems evaluated by the 2022 Annual Report by the Rand Corporation on prices paid by private health plans.[4] The average cost of hospital care in NYC is inflated by the high prices of some hospitals, moderated by the relatively low cost of public and safety net institutions.

	Rank of 311	Relative to Medicare
New York Presbyterian Healthcare	6	366%
NYU Langone Health	23	316%
Montefiore Medical Center	36	295%
Northwell Health	71	266%
Mount Sinai Health System	100	246%
NYC Health & Hospitals	299	160%

Even before the recent onset of inflation, health care costs in NY were increasing. From 2016-2020, *all* the increase in commercial health insurance costs in New York City were caused by price increases. Leading the parade: A whopping 31 percent jump in inpatient hospital prices – more than double the rise in outpatient costs and almost four times the rate of growth in doctors' prices.

The insurers covering NYC employee reported similar patterns. Payments for employees covered by the Comprehensive Benefit Plan increased 32% between 2014 and 2018. While some of the change was due to a growing labor force, most was increased spending per capita. Professional services costs grew by 18%. Hospital spending by 41%.

There are only two ways to contain the City's cost of health insurance for its employees. Reduce benefits and shift the burden onto employees. Or find a way to moderate prices. New York State, once a leader in regulating hospital prices, opted for deregulation in 1996. Since then, it has left it to the service purchasers to do the dirty work of confronting the deeply entrenched, politically potent, private hospital industry. The potential for a third way exists. It requires that City government use its million covered lives as leverage to challenge hospital prices.

NYC Council Testimony
Feb 23, 2023
Barbara Caress

[4] https://www.rand.org/pubs/research_reports/RRA1144-1.html

NYC Council Speaker: Hon. Adrienne Adams

Committee: Health

Health Hospitals Transparency Testimony February 23, 2023

There should be more transparency by hospitals when a patient is provided medical services. The hospital's costs/rates should be available.

I am a Black elderly woman, on a fixed income budget with health Insurance: Emblem Health, formerly HIP. During a recent annual physical visit, my doctor ordered an EKG exam. A technician appears, in minutes and administered the exam. The following day, I received a bill in *MYChart* for my share of the EKG payments, which I paid. The same day I called Emblem Health to have the charges reversed. I also contacted NYU Langone Health disputing the charges, since I was never informed there was a payment due, before having the exam.

Fact: When arranging for the annual physical there is a box that is checked: The patient will be responsible for bills incurred. However, there is a box that asks will insurance be used. I checked yes, insurance will be used.

When I go to the dentist, all rates are discussed and agreed upon before services are performed.

I have not received an answer from Emblem Health or NYU Langone Health. In MYChart there was a message, if you have additional questions call. Yes, I want my funds returned to my account.

No one should enter a hospital and procedures completed without the knowledge of costs required, unless there is an emergency. I am hoping this NYC Council Committee will be able to level the playing field when patients enter the hospital seeking services.

Michelle D Winfield

TESTIMONY OF SUE ELLEN DODELL
CONCERNING INT. 844 of 2022
BEFORE THE NEW YORK CITY COUNCIL
COMMITTEES ON HEALTH AND HOSPITALS
FEBRUARY 23, 2023

Thank you, Chairs Narcisse and Schulman and other Committee members.

My name is Sue Ellen Dodell, and I am a life-long New York City resident. I'm testifying on behalf of the New York City Organization of Public Service Retirees to bring to your attention some concerns about Int. 844 that should be considered before you vote on this legislation.

I have been an attorney in City government for more than 43 years: I was an Assistant Corporation Counsel, was the Deputy General Counsel in the Comptroller's Office, and, for 17 years, was the General Counsel of the Campaign Finance Board, from which I retired in 2017. I am now a hearing officer at OATH. In my years in City service, I have drafted many bills and have appeared many times in this room to testify before the Council. I also am a wife and mother and have used the services of both private and City-run hospitals.

While the stated goals of Int. 844 – to provide the public with the cost of hospital procedures and to audit the expenditures of the City on health care – are laudable, they can be accomplished without a costly new bureaucracy.

Int. 844 assumes that transparency in hospital costs will lead to lower costs for healthcare consumers and the City. In fact, the legislation is not likely to accomplish this goal and does not include the persons who should be at the table to deal with health care costs.

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 so 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? The last thing the City needs is another agency with responsibilities that are redundant with those of other agencies,

Int. 844 cannot affect the pricing of private hospitals. As you know, the State used to regulate prices for hospitals, but Governor Pataki removed these regulations in the mid-1990’s, which led to the closing of many small hospitals. Since 1997, each hospital has had to negotiate prices with each insurer. Although the State urged hospitals to compete with one another to attract patients and doctors by reducing prices and improving services, that has not worked. We need a return to some regulation by the State.
I think it's very telling that you are considering a resolution today (T2023-3046) 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.

Int. 844 doesn't 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: hospitals, pharma, unions, physicians, nurses, the Mayor, Comptroller, and City Council, current employees, and retirees, and have that Commission look at all aspects of health care, including how to save money. You should not just focus on hospitals and should not just do an "audit" of expenditures on employee and retiree health care spending.

If the City really wants to reduce expenditures on health care, it should do a better job right now of negotiating with its insurers and health care facilities. Why is the City not using its leverage to improve services and reduce cost? Every Mayor has said that he wants to reduce healthcare costs and somehow that never happens! A Blue-Ribbon Commission would get to the bottom of this!

The bill assumes that transparency in hospital costs, something that federal law currently mandates, will bring costs down for consumers and for the City budget. When the bill was introduced, it was stated that it could bring costs down by $2 billion. But this is not likely to be the case: 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 and other healthcare facilities.

The bill assumes that if a NYC resident knows the price of a procedure, he or she will go to the cheapest hospital, but there are many considerations in choosing a hospital: among them, where your doctor is affiliated, which hospital has better outcomes, and of course, whether your insurance, if you have it, will cover a procedure at that hospital.

When this bill was introduced, the cost of C-sections at various hospitals was mentioned. Most expectant mothers choose a doctor or midwife for their delivery because they have had a long relationship with them, and then will go to the hospital with which a doctor has privileges. Generally, doctors and patients avoid planned C-sections, which are far more costly to consumers and more dangerous to women than vaginal births. If a woman is having a C-section, it is likely because of a serious concern about her health, the health of her baby, or it is an emergency, and there will not be time to shop around for a cheaper hospital.

Moreover, if someone has any type of emergency, they will not be shopping around for the cheapest hospital.

In short, Int. 844 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.

Sue Ellen Dodell

Bronx, NY 10471
suedodell@gmail.com

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 844 Res. No. _____

☐ in favor ☒ in opposition

Date: 02/23/23

(PLEASE PRINT)

Name: DAVID RICH

Address: 555 W. 57th ST

I represent: GNYHA

Address: 555 W. 57th ST

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 844 Res. No. _____

☐ in favor ☐ in opposition ~~mixed view~~

Date: _____

(PLEASE PRINT)

Name: Lisa Young Rubin on panel with Sue Ellen Dodell

Address: NYC NY 10011

I represent: NYC Organization For Public Svce Retirees

Address: nycretirees.org

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 844 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Leslie Moran

Address: 41 State St Albany

I represent: NY Health Plan Association

Address: 41 State St Albany

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 844 Res. No. _____

☐ in favor ☐ in opposition ☒ Comments

Panel with Lisa Rubin

Date: 2/23

(PLEASE PRINT)

Name: Sue Dodell

Address: 5901 Delafield Avenue

I represent: NYC Org. of Public Service Retirees

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 844 Res. No. _____

☑ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: Pat Kane - NYSNA

Address: 131 West 33rd Street

I represent: NYSNA

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: Joseph Telano

Address: Brooklyn, NY 11215

I represent: Primary Care Development Corp.

Address: 45 Broadway, 5th floor NY, NY 10006

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/23/23

(PLEASE PRINT)

Name: Daniel Pollak

Address: _____

I represent: First Deputy Commissioner, Office of Labor Relations

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: Michelle Morse - Chief Medical Officer

Address: NYC Health Department

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 214 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Claire Levitt

Address: _____

I represent: OLR

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: CORA OPSAHL

Address: NYC 10009

I represent: 32 BJ Heath Fund

Address: 25 W 18th St, NYC 10011

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: [illegible]

Address: 1825 Madison Av Apt 6F NYC

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: AUREA A. MANGUS

Address: NYC 10031

I represent: DC 37 Retirees

Address: 75 Maiden Lane NYC

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: Kevin Marra

Address: _____ NEW YORK

I represent: Power to the Patients

Address: NEW YORK

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: NEAL FRUMKIN

Address: _____

I represent: DC 37 Retirees Association

Address: 75 Maiden Lane

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Heat Pump Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kevin Cahill

Address: 1017 Jefferson St

I represent: NYC Carpenters

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/23/23

(PLEASE PRINT)

Name: Joseph Telano

Address: 45 Broadway, 5th Floor NY, NY 10006

I represent: Primary Care Development Corp.

Address: 45 Broadway, 5th Floor NY, NY 10006

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 2/23/2023

(PLEASE PRINT)

Name: Henry Garrido

Address: 125 Barclay Street NY NY 10007

I represent: Executive Director, DC37

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: Feb 23, 2023

(PLEASE PRINT)

Name: BARBARA CARESS

Address: _____

I represent: PSC/CUNY

Address: 25 Broadway 9th fl. 10004

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Pat Kane

Address: _____

I represent: New York State Nurses Assoc

Address: 131 West 33rd St

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