New York City Council

Committee on Hospitals
Committee on Health

Hearing Testimony:
"Oversight: Rising Health Care Costs"

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GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Rivera, Chair Levine, and members of the Committees on Hospitals and Health, my name is Andrew Title, Assistant Vice President at the Greater New York Hospital Association (GNYHA). GNYHA proudly represents all the hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island. I appreciate the opportunity to speak with you today about health care costs and how they affect New Yorkers.

GNYHA believes health care is a human right and that everyone should have access to quality care. Both the government and the health care community have made great progress towards this goal. Millions more have coverage because of the Affordable Care Act (ACA), Medicaid expansion, and the Child Health Plus, Family Health Plus, and Essential Plan programs. GNYHA, in partnership with 1199SEIU United Healthcare Workers East, helped to develop and support many of these programs. As a result, the uninsured rate in New York State has been cut in half, to 5%[1]—about half the national average.

Despite these insurance coverage expansion successes, too many people across this City and country struggle to afford care, and GNYHA is committed to addressing that. Today, I hope to shed some light on this complex problem.

I will touch on four main topics: the challenges facing New York hospitals, factors that influence health care costs, state and national efforts to protect consumers from unexpected medical bills, and possible solutions.

A Time of Peril for New York Hospitals

New York's vital community hospitals face unprecedented threats to survival. Around 30 are on a statewide Department of Health (DOH) "watch list" for closure. These hospitals have less than 15 days cash on hand, and require regular, significant infusions of State dollars just to keep the lights on and meet payroll. There are watch list hospitals in the Bronx, Brooklyn, and Queens;[2] Manhattan and Staten Island also have severely challenged institutions. DOH has provided these hospitals with around $800 million in the current State fiscal year (FY).

Part of the reason these hospitals struggle is that they care for many Medicaid and Medicare beneficiaries and uninsured New Yorkers. Medicaid rates cover only 74% of the cost of caring for these patients,[3] meaning critical safety net hospitals lose money on almost every individual they treat; Medicare's payments are only slightly higher.

From 2008 to 2018—a full decade—New York State hospitals did not receive a single Medicaid rate increase as operating, labor, and supply costs such as pharmaceuticals steadily rose. Consequently, New York hospital margins are among the lowest in the country: the State average was only 1.8% in 2017,

[1] However, around one million New Yorkers still lack care, and we have a plan to get them covered. We know that about a third of the uninsured are already eligible for Medicaid but not enrolled; a third are eligible to purchase private individual coverage through the State health exchange but find it unaffordable; and the remaining third are low-income undocumented immigrants who are not eligible for any form of subsidized coverage other than emergency Medicaid. GNYHA supports policies to expand access to care for each of these groups, including: streamlining Medicaid enrollment and renewal, campaigns to enroll individuals in public insurance programs for which they are eligible, State-funded tax credits to supplement available Federal tax credits so coverage is more affordable for individuals, and expanding the Essential Plan to wrap around emergency Medicaid for low-income undocumented immigrants (as proposed in A.5974/S.3900 and supported in Council resolution 0918-2019).

[2] New York City hospitals in the program include Brookdale Hospital, Jamaica Hospital, Flushing Hospital, St. John's Episcopal Hospital, Interfaith Medical Center, Kingsbrook Jewish Medical Center, and Wyckoff Heights Medical Center.

[3] GNYHA analysis of New York State Institutional Cost Reports, 2017.

compared to 5.9% nationally.[4] This severely limits these hospitals' ability to invest in facilities, equipment, and staff.

To stay afloat, hospitals must, if they can, negotiate higher rates with commercial insurers to cover their Medicare and Medicaid losses. But not all hospitals care for enough privately insured patients to achieve this "cost shift," which is the cause of the financial distress we have seen among our safety net hospitals.

In the FY 2018-19 State budget, 1199SEIU and GNYHA convinced Albany to increase Medicaid rates by 2%, but that relief for safety net hospitals is now in jeopardy. As has been widely reported, the Division of the Budget (DOB) estimates the FY 2020 Medicaid gap at $3 to $4 billion. Since 2013, the Legislature and Executive Branch have limited Medicaid spending growth to the rate of medical inflation, usually around 3% (the Medicaid "global cap"). Decreased Federal assistance, increased labor costs, and higher Medicaid enrollment have placed enormous strain on this artificial boundary.

Meanwhile, the Trump administration is doing everything it can to undermine urban hospitals, first by seeking to repeal the ACA without a replacement and now by refusing to defend the landmark law in court. Compounding the problem, cuts to the Medicaid Disproportionate Share Hospital (DSH) program—which supplies $3.5 billion annually to New York's public and voluntary safety net hospitals, in recognition of the uncompensated care they provide from treating the uninsured and Medicaid patients—are scheduled to go into effect on December 20.

Despite all these challenges, hospitals—unique among health care providers—are available 24 hours a day, 365 days a year. They save lives at every moment of every day, regardless of patients' ability to pay or insurance status. And as the largest non–public sector employer in the City, our hospitals are also the economic anchors of their communities.

Our public and voluntary hospitals serve huge numbers of Medicaid patients and provide the same high-quality of care to all. They have maintained major ambulatory care networks for many years that focus on providing care to the Medicaid patient population and other vulnerable New Yorkers, including the uninsured. In 2017, New York State hospitals provided over 8.5 million clinic and ambulatory care services to Medicaid and uninsured patients,[5] $3.4 billion in Medicaid services, $600 million in financial assistance, and $988 million in subsidized health services.[6] While for-profit hospitals are becoming the norm in other states, New York institutions continue to pursue their not-for-profit and public mission: caring for the most vulnerable.

What's Behind Rising Costs?

It is clear that health care costs are rising and much of the burden is falling on patients. This is especially true for those covered by commercial plans, who face higher insurance premiums, out-of-pocket costs, and prescription drug prices. (These costs also affect self-insured businesses and union benefit plans, which may or may not decide to pass increased costs onto beneficiaries.)

The Kaiser Family Foundation has compiled data on these trends. From 2009 to 2019, average annual premiums for family coverage topped $20,000, up from around $13,000. The worker contribution also rose

[4] New York margins: GNYHA analysis of New York State Institutional Cost Reports; U.S. margins: Medicare Payment Advisory Commission analysis of Medicare Cost Report data (December 2018).
[5] GNYHA analysis of New York State Institutional Cost Reports, 2017.
[6] Internal Revenue Service Form 990 reports.

during that period, from $3,515 to $6,015.[7] Deductibles rose 162%, far outpacing family premiums (54%), overall inflation (20%), and worker earnings (26%).[8] From 2006 to 2016, overall out-of-pocket spending "rose by 54%, from an average of $525 . . . to $806."[9] Unsurprisingly, more and more insured Americans say it is difficult to afford health care.[10]

There are many reasons why health care costs are rising. They include the state of the economy, medical inflation, insurance and pharmaceutical company business decisions, and local and Federal government policy. Provider and hospital practices (and the prices they lead to)—while important—are just one component of this dynamic.

Recently, many have focused on hospital sticker (or "charge master") prices, which hospitals are required to set. While these prices are important, the vast majority of patients at New York hospitals pay much less than these list prices. Similarly, commercial insurers and public insurance programs pay hospitals much less than those prices for the services they deliver to patients. This is because providers (including hospitals) and insurers *negotiate rates* for health care services that are typically much lower.

Here are some factors that contribute to what New Yorkers—and hospitals—pay for their health care.

Escalating insurer profits There is a huge mismatch between the size and scope of many of the insurance companies hospitals must negotiate with and the hospitals themselves. Our hospitals—all public or not-for-profit—negotiate with several behemoth, national, publicly traded insurance companies. Unlike our hospitals—which only serve their patients and communities—these corporations answer to their shareholders. They are hugely profitable, as evidenced by the latest numbers from the third quarter of 2019. UnitedHealthcare reported profits of $60.4 billion;[11] Anthem, Empire's parent, reported $1.2 billion in profits, up 23.2% from the same one last year;[12] and CVS, which now owns Aetna, reported $3.9 billion.[13]

These profits are larger than the entire annual budgets of many of our hospitals and health systems. Our hospitals' resources are a drop in the bucket compared to the resources of these for-profit companies, which have maximum incentive to pay the lowest possible prices so they can provide a return to their investors. They thus drive very hard bargains, and then engage in practices—such as payment denials for medically necessary services—to avoid or postpone payments to hospitals for as long as possible.

In this daily war against massive for-profit companies, New York's hospitals are overmatched, and fighting their payment denials and delays is an enormous administrative burden. Some health systems have entire departments dedicated to this task. Every hospital with any commercial patient base struggles with ongoing, massive unpaid debt for services already delivered to patients. As a result, New York's hospitals effectively

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[7] Kaiser Family Foundation, "2019 Employer Health Benefits Survey." https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/

[8] Ibid.

[9] Claxton, G., Levitt, L., Rae, M., Sawyer, B. "Increases in cost-sharing payments continue to outpace wage growth" Peterson-KFF Health System Tracker. June 15, 2018. https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/

[10] Ibid.

[11] UnitedHealth Group Reports Third Quarter 2019 Results. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2019/UNH-Q3-2019-Release.pdf

[12] Haefner, M. "Anthem's profits grow to $1.2b," Becker's Hospital Review. October 23, 2019. https://www.beckershospitalreview.com/payer-issues/anthem-s-profits-grow-to-1-2b.html

[13] CVS Health Reports Third Quarter Results. https://s2.q4cdn.com/447711729/files/doc_financials/quarterly/2019/q3/Q3-19-Earnings-Release.pdf

provide loans to highly profitable corporations. It's worth noting that a 2019 RAND Corporation study found that the prices private insurers in New York State pay hospitals are the third-lowest in the country.[14]

One of the most egregious examples of insurer bad behavior is issuing "admission denials" after a patient's hospital stay. By arguing (often dubiously) after the fact that care could have been given in an outpatient setting—insurance companies can cut around 70% of the total payment. Between 2006 and 2010 at one hospital, the admission denial rate rose 250%, reaching 2% of annual revenue—roughly the median hospital operating margin in New York State.

While comprehensive denials data can be difficult to find, independent analyses found that insurers on the national health exchange rejected one out of every five claims in 2017[15] and that private Medicare insurers "overturned 75 percent of their own denials during 2014–16."[16] Unfortunately, blanket denials are becoming a business model, with severe consequences for hospitals without the power to stand up to massive insurance companies.

Escalating drug prices. Hospitals have little to no control over the cost of the pharmaceuticals they need to deliver patient care. Like the insurance industry, drug companies reap massive profits year after year. From 2008 to 2016, according to the Petersen-Kaiser Family Foundation Health System tracker, the "costs of oral and injectable brand-name drugs increased annually by 9.2 percent and 15.1 percent," oral and injectable specialty drugs by "20.6 percent and 12.5 percent," and oral and injectable generics by "4.4 percent and 7.3 percent."[17]

Other costs Factors that also contribute to health care costs—for both hospitals and patients—include rising medical device costs, medical malpractice costs (the cost of liability insurance in New York is perennially among the highest in the nation), high cost-of-living, high labor costs, and proliferating government mandates (hospitals and health care in general are very highly regulated). While reasonable people can disagree on the causes of these conditions, there is no doubt that they ultimately contribute to higher health care costs for everyone.

Conclusion New York City's not-for-profit and public hospitals provide care to all New Yorkers of all income groups. They are there for all of us in emergency situations, no questions asked. They provide myriad unreimbursed or under-reimbursed benefits for their communities, including school-based health clinics; ambulatory care networks; training of physicians, nurses, physician assistants, pharmacists, and other health care professionals; cutting-edge research that leads to cures and saves countless lives; and investments in the latest health technology.

Unlike in other states, where most hospitals are not Medicaid providers, all of our hospitals provide high-quality medical care for Medicaid patients. Our city's hospital infrastructure benefits every New Yorker

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[14] W. Chapin and C. Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," RAND Corporation, p. 20. Available at https://www.rand.org/pubs/research_reports/RR3033.html.

[15] Henry J. Kaiser Family Foundation, "Analysis: Marketplace Plans Denied an Average of Nearly One in Five Claims in 2017 with Wide Variations across Insurers," February 25, 2019. Available at https://www.kff.org/private-insurance/press-release/analysis-marketplace-plans-denied-average-of-nearly-one-in-five-claims-in-2017-with-wide-variations-across-insurers/.

[16] U.S. Department of Health and Human Services Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials," September 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[17] Cox, C., Kamal, R. "Recent trends in prescription drug spending, and what to look out for in coming years." Peterson-KFF Health System Tracker. December 9, 2015. https://www.healthsystemtracker.org/brief/recent-trends-in-prescription-drug-spending-and-what-to-look-out-for-in-coming-years/

and demands our protection. Hospitals provide these benefits to the people of New York City and more. Do insurance companies do the same?

Protecting New Yorkers from Surprise Bills

When patients with commercial (or employer-provided) insurance get care, they shouldn't be left with huge unexpected bills because they technically left their insurer's provider network. Thankfully, New York State has one of the most comprehensive laws in the country protecting individuals from these "surprise bills." These bills occur when patients, through no fault of their own, receive care from out-of-network providers in emergency situations or when they access care at an in-network hospital but are treated by out-of-network physicians.

GNYHA has long supported protecting patients from high out-of-pocket costs in surprise bill situations. We worked closely with legislators and State officials on the enactment of New York State's landmark "out of network" (OON) legislation, which took effect in 2015. The law guarantees that when patients need emergency out-of-network treatment, insurers cannot charge them more out-of-pocket than what they would have paid at an in-network provider. It also established a dispute resolution process for physicians and insurers if they failed to agree on payment.

In addition to emergency situations, the OON law applies when consumers make efforts to plan ahead and only use in-network providers, yet still get an out-of-network bill. The OON law has effectively taken consumers out of a process that was causing severe financial harm. A 2019 Department of Financial Services study called the law a resounding success, reporting that from its inception in 2015 through 2018, the OON law "saved consumers over $400,000,000," "reduced OON billing in New York by 34%," and "lowered in-network emergency physician prices by 9%."[18]

This year, New York Governor Andrew Cuomo signed legislation amending the OON law. Most notably, it brings hospitals into the dispute resolution process, which previously only applied to physician payments. It also requires that in these situations, insurers must pay hospitals at least 125% of the previous in-network rate and exempts certain safety net hospitals. GNYHA had significant concerns with the original version of this legislation because it would have increased the already considerable leverage national, for-profit insurance companies have when negotiating with New York's not-for-profit and public hospitals. However, we were able to work with stakeholders to revise the bill to limit the harm to hospitals, ensure that employers and insurers are not subject to unreasonable out-of-network charges and, of course, continue to protect consumers in surprise bill situations.

While New York's OON law is a great achievement, it only applies to state-regulated plans—not those established under the federal Employee Retirement Income Security Act (ERISA). These insurance products commonly cover people employed by large, self-insured companies or under union benefit plans. At least partly as a result, Congress is presently debating various plans to extend similar protections to these Americans. GNYHA fully supports enactment of Federal legislation to protect consumers from surprise bills and is working closely with elected officials in Washington to shape the legislation in a way that does not substantially harm hospitals.

GNYHA and many other health care groups believe that as the first state to adopt comprehensive, effective surprise billing legislation, Washington should follow the "New York model." The basic principles are as follows: hold patients harmless from surprise bills; don't preempt state laws that address surprise bills (as long as they protect patients); and create a dispute resolution process similar to New York's, rather than one that relies on arbitrary benchmark payment rates. We believe models that propose payment for surprise

[18] Department of Financial Services, "Report on the Independent Dispute Resolution Process," September 2019, p. 2.

bills at median in-network rates would give for-profit insurance companies even more power over local hospitals and result in diminished provider networks, limiting patient access to the doctors and hospitals they want to see. We will continue to work with Congress to pass legislation that fully protects consumers but does not give insurers undue leverage in contract negotiations or create incentives for insurers to offer more limited provider networks.

Hold Profit-Motivated Insurers, Big Pharma Accountable

Addressing rising health care costs requires us to look at the big picture. The best place to start is bringing the insurance and pharmaceutical industries in line, which reap record profits without regard for the best interests of patients.

Insurance People are rightly upset with insurance companies for high copays and deductibles, denials of medically necessary care, acres of red tape, sudden limits to provider networks, cancelling contracts with trusted physicians and hospitals, and absurd prior authorization practices. GNYHA supports changes to State and Federal law to rein in these abuses, including bills requiring that insurers simplify their rules and procedures, pay interest on overturned denials, and simplify overly complex administrative procedures.

GNYHA supports policies to help people afford their insurance by improving the ACA. These include increasing exchange subsidies, restoring so-called cost-sharing reduction funding to help individuals afford premiums, restoring the individual mandate, fixing the "family glitch" and coverage gap, rescinding negative Trump administration ACA actions, funding outreach and education, and creating insurer risk protections and high-risk pools. (Most of these would require Federal action, although some could be addressed at the State level.)

Pharmaceuticals Similarly, bad actors in the pharmaceutical industry have exploited vulnerable people that depend on their lifesaving drugs. One of the most publicized examples is the spectacularly priced Sovaldi, produced by Gilead Sciences, which treats Hepatitis C and was at one point priced at $168,000 per course of treatment. But drug companies have also raised prices for therapies that have existed for years, like insulin, or simply refused to produce critical products in sufficient quantities (like saline) because their expected profit is too small, resulting in shortages for patients and crises for hospitals. It's time for Congress to allow the Federal government to use its purchasing power to negotiate drug prices with manufacturers on behalf of Medicare beneficiaries, which it is currently prohibited from doing, and take other steps to bring pharmaceutical costs under control.

Hospitals Hospitals are committed to doing their part to lower health care costs for patients through a host of quality initiatives designed to reduce hospitalizations, emergency room use, and readmissions. Starting in 2011, New York State, under Governor Cuomo's leadership, initiated major Medicaid reforms designed to improve quality and efficiency, with a major emphasis on care management for all Medicaid beneficiaries. Later, as part of the State's Delivery System Reform Incentive Payment (DSRIP) program, hospitals and other providers created large collaborative groups known as Performing Provider Systems (PPS).[19] Nearly all of the hospitals in New York City participate in DSRIP, whose goal is to fundamentally restructure the health care delivery system and reduce avoidable hospital use by 25% over five years.

GNYHA and its members also recognize that the bills New Yorkers receive from hospitals can be confusing and stressful. This is partly because hospital billing departments have to deal with a multiplicity of insurance companies and plans, each with their own payment policies, and have no way of knowing what (or even whether) these insurance companies will pay for services that hospitals have already delivered to patients.

[19] See https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm.

Most important, we realize that we can always do better, and that's why we're working with our members to improve the billing process and make sure consumers better understand their options and obligations, including hospital financial assistance policies. GNYHA also supports legislation that would ban hospitals from sending out-of-network bills directly to consumers—other than the amounts they would owe if they had been treated by an in-network hospital—if they assign benefits to providers (S.9077 of 2018). The bill would also ban "balance billing" of the patient by the hospital.

Thank you for the opportunity to provide testimony on this important issue. I am happy to answer any questions.