

# HOSPITAL PRICES:

---

# UNSUSTAINABLE AND UNJUSTIFIABLE



All data contained in this paper are derived from 32BJ Health Fund claims data or other cited sources.

March 17, 2022

**Revised November 1, 2022**



---

## **ABOUT 32BJ HEALTH FUND**

The 32BJ Health Fund is an unusually effective collaboration between a labor union (SEIU 32BJ) and management (represented collectively by the Realty Advisory Board in New York) to provide affordable, comprehensive, and innovative health coverage to working people. The Fund aggregates employer contributions from 5,000 employers, ranging from many small businesses to global real estate firms, and uses contributions to provide benefits to 200,000 people.

The 32BJ Health Fund serves members of the SEIU 32BJ union and their families. The union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food service workers, and airport workers in 11 states and Washington, D.C.

The 32BJ Health Fund receives all of our claim data from our vendors, which uniquely allows us to leverage data to make benefit and plan design decisions in the best interest of our participants, so that we can maximize the benefits they receive.

---

# EXECUTIVE SUMMARY

The 32BJ Health Fund (the “Fund”) is committed to providing high-quality and affordable healthcare for our participants and their families. However, like many healthcare purchasers, our mission is jeopardized by the ever-rising cost of healthcare. Through an in-depth analysis of our claims data and other publicly available information, the Fund determined that the leading driver of these costs is the skyrocketing price of hospital care, especially in the New York City market. Unless dramatic action is taken to rein in hospital pricing, access to affordable care for our participants, as well as millions of others who depend on hospitals to provide critical care, is in jeopardy.

In this report, we identify where hospital prices are highest and how they impact our participants. By engaging in a thorough study of our own data, and the broader research literature, we address some of the most common misconceptions about hospital prices and identify policy interventions that have proved effective in various locations around the country.

## Key Findings

- + Hospital prices represent the most significant driver of healthcare costs, accounting for one of every three dollars spent on healthcare in the U.S. and representing a majority of the costs of the 32BJ Health Fund.
- + Private hospital systems in New York City charge the Fund on average more than 300 percent of what they charge Medicare for the same services. Medicare prices are calculated to allow a reasonably efficient system to function effectively when receiving these rates.
- + Prices charged for the same service vary widely across different New York City hospital systems. Private systems in New York City also charge significantly more than similarly large private hospital systems in Boston.
- + By driving up healthcare costs unnecessarily, high hospital prices negatively impact working people’s access to affordable care.
- + High hospital prices drive down the wages of working people. For example, SEIU 32BJ estimates that, if healthcare costs had increased at the rate of inflation from 2014 to 2023, an additional \$5,000 in annual wages would have been available for union members.
- + High hospital prices cost government entities a significant amount in taxpayer dollars. By paying hospital prices above Medicare’s rates, New York City may be overpaying by as much as \$2.0 billion. At the same time, private hospitals receive hundreds of millions in property tax exemptions from the city.<sup>1</sup>
- + Evidence does not support many reasons given by hospitals for higher prices, like the need to subsidize public or charity care, provision of higher quality care, or impact of COVID-19 to hospital financials – nor does consolidation drive down prices for consumers.

## POLICY INTERVENTIONS TO REIN IN HOSPITAL SPENDING

- ★ **Aggregated Purchasing Coalitions.** Large purchasers of healthcare, particularly government entities and Taft-Hartley Union Health Funds, could pool their buying power and negotiate significant cost savings.
- ★ **Restrict Anti-Competitive Contracting by Large Hospital Systems.** Contract terms including all-or-nothing clauses, most-favored nation clauses, and anti-tiering provisions have become the target of State Attorneys General and State Legislators. In New York State, the HEAL law would help curtail these behaviors.
- ★ **Ensure Non-Profit Hospitals Act in Accordance with Non-Profit Principles.** A growing number of legislative and regulatory efforts are reining in profit-seeking behavior by non-profit hospital systems by revoking tax exempt status or mandating levels of spending on charity care and community benefits.
- ★ **Rate Regulation and Global Budgets.** Several states regulate the amounts hospitals can charge for various procedures, often tying prices to Medicare rates.

# TABLE OF CONTENTS

<b>Introduction and Background</b> .....	<b>5</b>
<b>Hospital Pricing Trends: An Analysis of 32BJ Health Fund Price Variation and a Comparison to Medicare</b> .....	<b>7</b>
Comparing Hospital Prices to Medicare .....	<b>7</b>
32BJ Health Fund Price Variation .....	<b>8</b>
<b>The Human and Societal Cost of High Hospital Prices</b> .....	<b>10</b>
Impact to Affordable Healthcare Access .....	<b>10</b>
Impact to Workers' Wages .....	<b>11</b>
Impact to Public Budgets .....	<b>12</b>
<b>Debunking the Myths on Why Hospitals Charge High Prices</b> .....	<b>13</b>
Myth 1: Higher Prices are Needed to Offset Medicare, Medicaid, and Charity Care .....	<b>13</b>
Myth 2: Consolidation Drives Down Prices .....	<b>14</b>
Myth 3: Higher Quality Deserves Higher Prices .....	<b>15</b>
Myth 4: The COVID-19 Pandemic Impact to Hospital Budgets .....	<b>15</b>
<b>The Path Forward: Interventions to Bring Down Hospital Prices</b> .....	<b>17</b>
Benefit Design Options .....	<b>17</b>
Aggregated Purchasing Coalitions .....	<b>18</b>
Legislative and Regulatory Action .....	<b>19</b>
<b>Conclusion</b> .....	<b>22</b>
<b>Appendix</b> .....	<b>23</b>
<b>Endnotes</b> .....	<b>24</b>

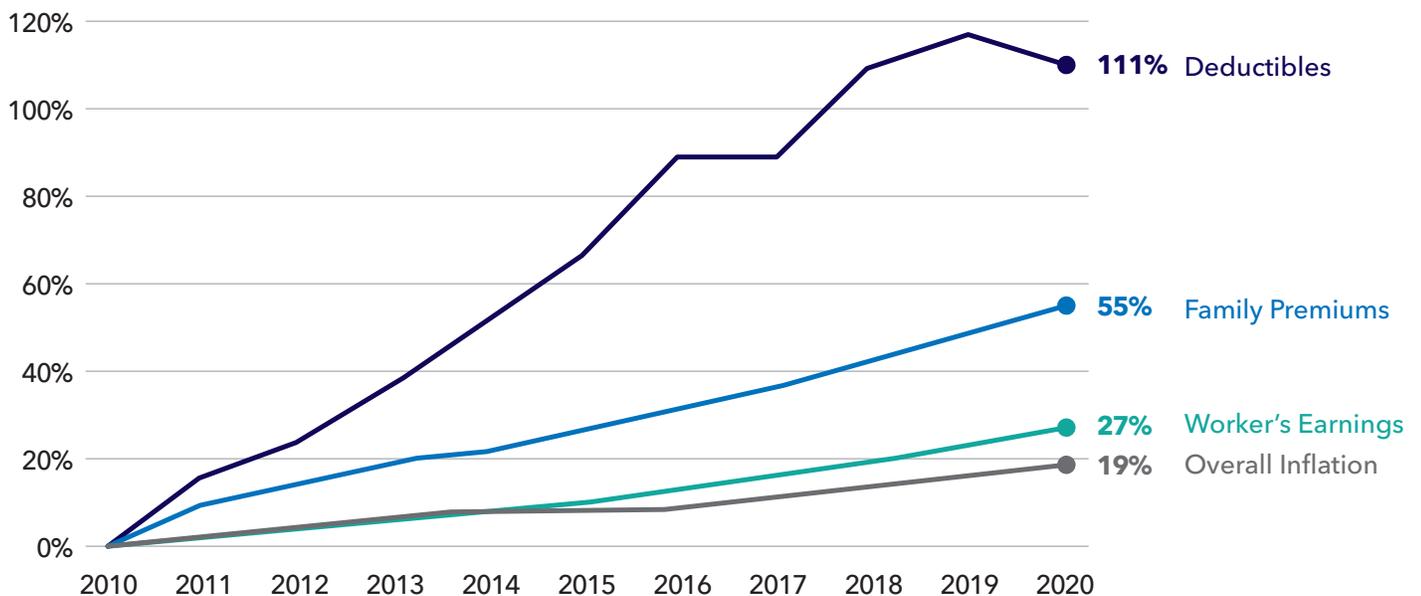
# INTRODUCTION AND BACKGROUND



Healthcare spending is a national crisis, exacerbated by high hospital prices. In 2020, healthcare spending increased 9.7 percent to \$4.1 trillion, growing faster than both the economy (3.4 percent) and consumer prices (7.0 percent).<sup>2</sup> The 2020 increase was more than double the 4.3 percent increase in 2019. While COVID-19, and the associated increase in Federal expenditures, contributed to the 2020 increase, rising hospital prices were the primary driver.

The high cost of medical care in the US is one of the greatest challenges the

country faces, and it affects everything from the economy to individual behavior. Hospitals receive roughly one dollar out of every three dollars spent on healthcare, or \$1.3 trillion in 2019.<sup>3</sup> The prices that hospitals charge greatly impact overall healthcare spending and are the number one driver of costs in healthcare. In turn, the rising cost of healthcare creates a higher bar for employers and individuals to afford health insurance, with increased cost sharing passed down to individuals through higher premiums and high-deductible health plans. Over the past decade, family premiums have risen by 55 percent and deductibles have risen by 111 percent, outpacing wage growth (Figure 1).<sup>4</sup>



**Figure 1.** Employer Premiums and Deductibles vs. Wage Growth and Overall Inflation, 2010-2020. **NOTE:** Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero. **Graph from the Kaiser Family Foundation.**

To illustrate the difference between the prices hospitals charge and the actual cost of care, we can use Medicare prices as a benchmark for comparison. Traditional Medicare calculates a base rate for specific procedures and adjusts the rate for patient severity, geography, and access to care, among other factors. Medicare rates are generally considered to cover costs that “reasonably efficient providers would incur in furnishing high-quality care.”<sup>5</sup> In 2016, private purchasers were paying 224 percent more for inpatient and outpatient care than Medicare, and by 2018, it was 247 percent.<sup>6</sup>

Unsurprisingly, 32BJ Health Fund has seen similar pricing trends in the New York City market. When looking at all hospital systems in New York City (including public systems like NYC Health + Hospitals), 32BJ Health Fund paid 240 percent of Medicare’s rates on average – and an average 316 percent of Medicare’s rates when looking at only private health systems in New York City.<sup>7</sup> New York City hospital prices paid by the Fund increased by 21 percent from 2016 to 2019, compared to an 8 percent increase in Connecticut, a 12 percent increase in Pennsylvania, and a 4 percent decrease in New Jersey during that same time period. In analyses by 32BJ Health Fund, enhanced quality, improved health outcomes, community benefit, or increased charity care could not explain the price variation.

In an analysis of 2019 claims data, the Fund spent \$1.4 billion on all health benefits, including medical, prescription drugs, vision, dental, and other ancillary benefits.<sup>8</sup> Moreover, the Fund spent 85 percent of all health benefit dollars, or \$1.2 billion of that \$1.4 billion, on hospitals, doctors, and medical staff.<sup>9</sup> Further, the Fund spent nearly 52 percent, or \$618 million of that \$1.2 billion, on hospital charges alone. Overall, hospital prices comprised 44 percent of our total health benefit spending in 2019.<sup>10</sup>



In this report, 32BJ Health Fund presents hospital pricing variation for episodes of care in our claims data against both the broader market and Medicare benchmarks. We then describe the negative impact that high prices have on individuals and public budgets before discussing and refuting the common arguments used to rationalize high hospital prices. Finally, we provide examples for how healthcare purchasers and public leaders can address the issue of high hospital prices in the U.S. healthcare system.

# HOSPITAL PRICING TRENDS: AN ANALYSIS OF 32BJ HEALTH FUND PRICE VARIATION AND A COMPARISON TO MEDICARE

## Comparing Hospital Prices to Medicare

Price variation is expected in a market as complex as health care, however, most purchasers of healthcare do not have access to meaningful quality and price information that helps them make prudent purchasing decisions. Although hospital prices are just one component of the healthcare system, they account for roughly 44 percent of total healthcare spending for the employer-insured population.<sup>11</sup>

In a RAND Institute study using data from more than three thousand hospitals nationwide, private payers spent \$33.8 billion from 2016 to 2018 – \$15.7 billion on hospital inpatient claims, \$14.8 billion on hospital outpatient claims, and \$3.3 billion on claims for professional care provided in a hospital. The study then compared the same services using Medicare rates. The same services provided by the same facilities totaled \$14.1 billion—\$6.9 billion on hospital inpatient claims, \$5.2 billion on hospital outpatient claims, and \$2.0 billion on claims for associated professional services. These differences imply that, overall, the private payers included in this study paid 240 percent of what Medicare would have spent at that time for the same services at the same set of facilities, a difference of \$19.7 billion. Put another way, if the private health plans participating in the study had paid hospitals using Medicare’s payment formulas during the same timeframe, the total allowed amount would have been reduced by \$19.7 billion, a potential savings of 58 percent.

32BJ Health Fund conducted a similar exercise. Using claims data from 2016 to 2019, 32BJ Health Fund spent more than \$1.9 billion in total hospital claims — \$1.1 billion on hospital inpatient claims, and \$825.5 million on hospital outpatient claims.<sup>12</sup> Using Medicare’s rates, the Fund would have paid \$803.7 million — \$589.2 million on hospital inpatient claims, and \$214.4 million on hospital outpatient claims, saving roughly \$1.1 billion or 58 percent.



## THE IMPORTANCE OF DATA-DRIVEN DECISIONS

32BJ Health Fund is unique in that it has access to its health plan data and can readily assess important factors like quality and price variation for those services its participants receive. While 32BJ Health Fund has been able to leverage this data to engage in progressive healthcare initiatives focused on elevating quality, high value, and better health outcomes for its participants, hospital prices continue to pose a threat to the financial stability of the Fund.

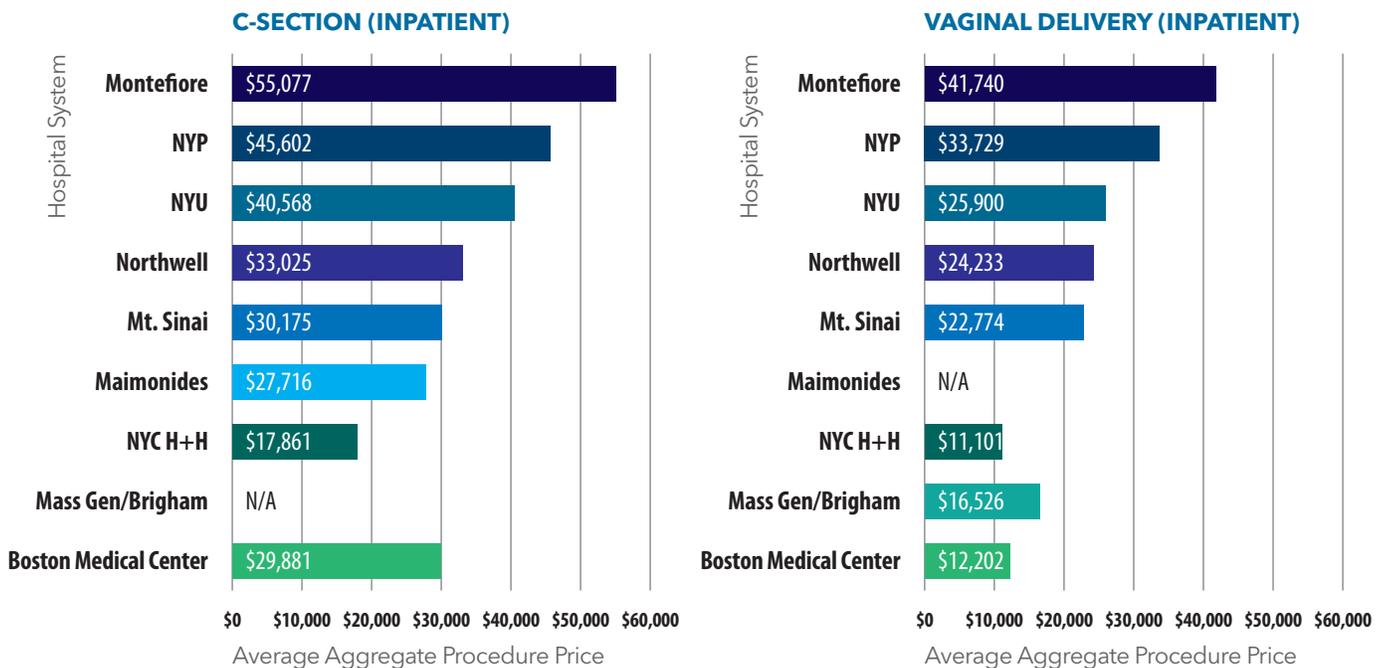
### 32BJ Health Fund Price Variation

Another analysis by 32BJ Health Fund looked at common procedures among ten major urban health systems in New York City and Boston: Mount Sinai, NewYork-Presbyterian (NYP), NYU Langone Health, Northwell Health, Montefiore Medical Center, Maimonides, NYC Health + Hospitals, Mass General Brigham, Boston Medical Center, and Cambridge Health Alliance (for full data, see Appendix Tables 1 and 2). The analysis included claims incurred in New York City, Long Island, and Boston from 2019 to 2021.

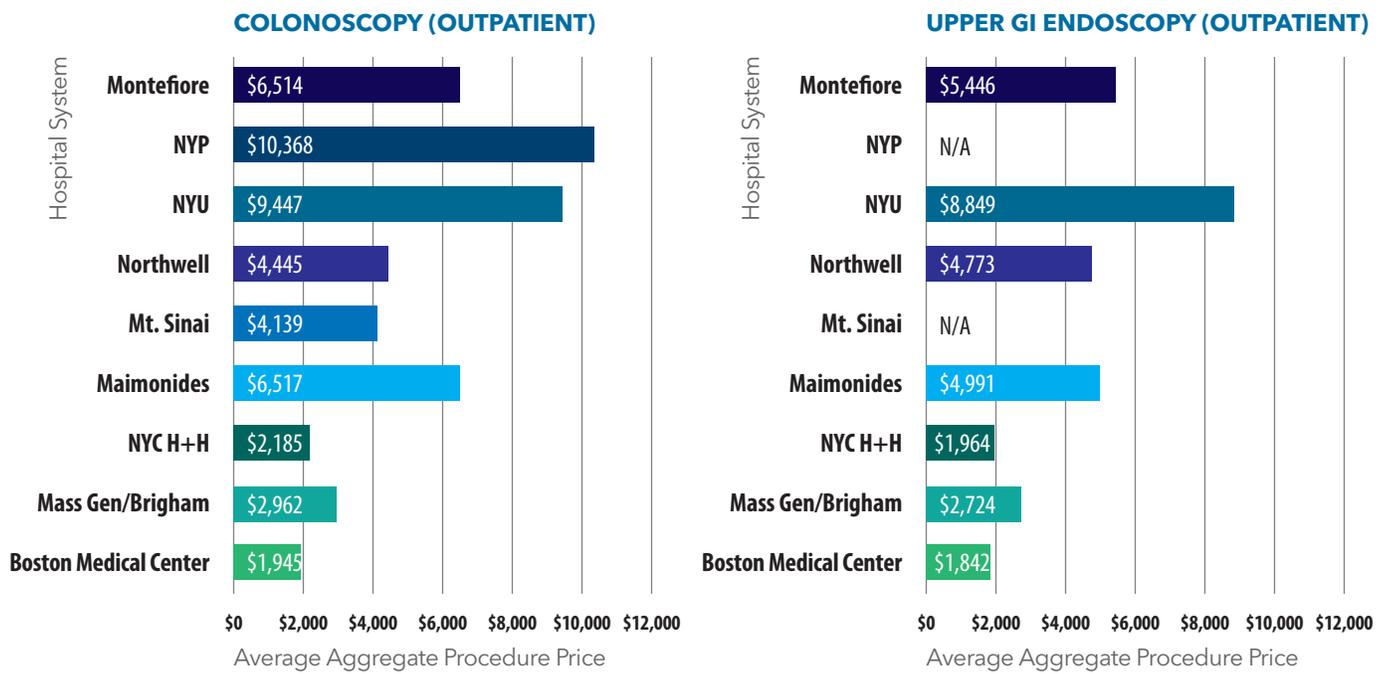
The procedures in this analysis were identified using PROMETHEUS Analytics methods, the industry standard in defining episodes of care for reimbursement and bundled payment. Episodes were defined by CPT/HCPCS and ICD-10 procedure and diagnosis codes. These episodes included both the index procedure and relevant look-back and post-discharge care. To reduce variation in costs, and to avoid mixing costs from different systems under the same episode of care, only costs associated with the index procedure were included.

After identifying each procedure, the total aggregate cost was calculated, including all facility and professional claims that occurred during the index procedure paid by either 32BJ Health Fund or the patient. The analysis included only planned inpatient and outpatient claims, excluding all emergency or emergent care. Costs were omitted from the analysis if a procedure at a given hospital system had a volume of fewer than five cases. Several methods were applied to ensure data reliability and reduce effects of skew, low procedure volume, or non-normal distribution.<sup>13</sup>

Figures 2A and 2B illustrate the high level of price variation paid by 32BJ Health Fund for similar services in the same geographic region or comparable urban geographies like Boston. When comparing prices across these markets, the differences are stark. For an inpatient C-section in New York City, prices varied from \$17,861 at NYC Health + Hospitals to \$55,077 at Montefiore Medical Center. A C-section cost about \$30,000 at Boston Medical Center. For an outpatient colonoscopy, prices ranged from \$2,185 at NYC Health + Hospitals to \$10,368 at NewYork-Presbyterian, with a price of \$2,962 at Mass General Brigham in Boston (which has made headlines in its own right for high prices in the Boston market<sup>14</sup>).



**Figure 2A.** 32BJ Health Fund Average Aggregate Hospital Inpatient Procedure Prices by System, 2019–2021  
Missing columns indicate there was not enough data available to calculate reliable results.



**Figure 2B.** 32BJ Health Fund Average Aggregate Hospital **Outpatient** Procedure Prices by System, 2019-2021  
Missing columns indicate there was not enough data available to calculate reliable results.

To help put these figures into context, a 2021 study in Health Affairs compared the hospital price of colonoscopy procedures against Medicare prices nationwide.<sup>15</sup> Authors observed that the Medicare reimbursement rate for a diagnostic colonoscopy in the hospital outpatient department was \$793, with “high-price” hospitals negotiating a commercial price of \$3,677 on average, 4.6 times the Medicare rate.<sup>16</sup>

Understanding variability in price and quality outcomes is paramount, and one of the reasons 32BJ Health Fund endeavors to ensure that our participants have access to high-quality, cost-efficient care centers for certain episodes, like maternity, in markets like New York City. Continuing to ensure that hospital prices are appropriately aligned with high value and quality health outcomes is essential to maintaining the fiscal sustainability of the high-quality healthcare benefits for which 32BJ Health Fund participants tirelessly work.

# THE HUMAN AND SOCIETAL COST OF HIGH HOSPITAL PRICES



Just over half of the total U.S. population receives health insurance through commercial plans that are offered by employers and unions, or that are purchased by individuals, with per-person spending on hospital services growing at a rapid pace when compared to the spending by federal programs like Medicare.<sup>17</sup> High hospital prices paid by commercial purchasers also have a direct negative impact on public budgets, which is compounded by the high

public cost of the tax-exempt status of New York City's non-profit hospitals. High hospital prices negatively impact public budgets, access to healthcare for working people, basic income growth, and are an overall drag on the New York City and U.S. economies.

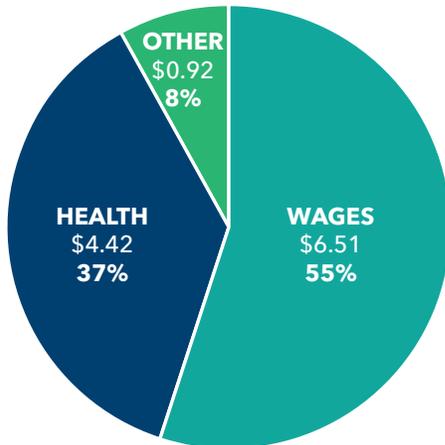
## Impact to Affordable Healthcare Access

The importance of access to high-quality and affordable healthcare is a generally accepted truth, even if the means to achieve this access are subject to debate. Understanding how pricing and affordability relate to access more broadly is important to continue supporting increased access to healthcare services for those who need it most. Access refers not only to the ability to obtain healthcare coverage, but also to individuals' ability to use that coverage affordably once they have obtained it. In other words, ensuring that premiums and other out-of-pocket costs are affordable is critical to providing sustained access to healthcare.

Many firms have outsourced low-wage workers because providing health benefits has become too expensive.<sup>18</sup> Both public and private purchasers/employers that continue to provide health benefits struggle with the increasing cost of healthcare premiums for their employees. Average costs for employer-sponsored health insurance increased 6.3 percent in 2021 to reach \$14,542 per employee, following 2020's increase of 3.4 percent.<sup>19</sup>

Even when employees have access to health coverage, polling suggests that a substantial percentage of individuals still avoid or delay care as a result of cost concerns. According to a recent study by the Kaiser Family Foundation (KFF), nearly half of insured adults report difficulty affording their out-of-pocket costs, and one in four report difficulty affording their deductible.<sup>20</sup> KFF also found that nearly half of U.S. adults say they put off or skipped some sort of medical or dental care in the past year because of the cost, and almost 30 percent report not taking medicines as prescribed due to cost. The challenge is even more acute with uninsured individuals, with one in three uninsured adults (30 percent) saying that they delayed or went without healthcare because of the cost. What do these numbers tell us about sustaining and increasing access to healthcare? Expanding the number of individuals covered by health insurance is only part of the solution. We must also increase access in both name and substance by increasing coverage that is meaningful, affordable, and within financial reach to participants.

## Impact to Workers' Wages



### SEIU 32BJ New York City Increases

The impact of high hospital prices is also felt by working New Yorkers in the form of reduced wages. Employee compensation is comprised of wages, benefits, and other costs, such as payroll taxes and unemployment contributions. As the cost of healthcare benefits increases, it applies pressure to the other areas of compensation, most notably on employees' wages. For the contract cycles covering the years 2014 to 2023, SEIU 32BJ has tracked the direct impact of escalating hospital prices in driving up the cost of healthcare. The cost of maintaining health coverage with no premium sharing now represents 37 percent of the total increase in compensation for the New York City workers of 32BJ. However, if healthcare costs had simply increased at the rate of inflation over this same time period, the union estimates that employers would have been able to provide an additional \$5,000 in annual wages to every 32BJ member without altering the design of their total compensation package. In a city where working-class people are constantly squeezed by the high cost of living, such an increase in wages could have a profound impact on the lives of working New Yorkers.

## OTHER WORKERS EXPERIENCE THE SAME PRESSURE



The United Auto Workers, Region 9A represents approximately 30,000 active and retired members throughout the Northeast. The vast majority of our members in the private sector rely on their employers for their health-care. Across all our locals the cost of health-care continues to rise each year. While at the bargaining table, our members are constantly faced with pressure from their employers to reduce the overall costs of their healthcare plans or face wage cuts or reduced increases because there is "only so much money to go around." In the end, the ones who are continuously hurt by rising healthcare and hospital costs are our members.

**Beverly Brakeman**, Regional Director of United Auto Workers Region 9A



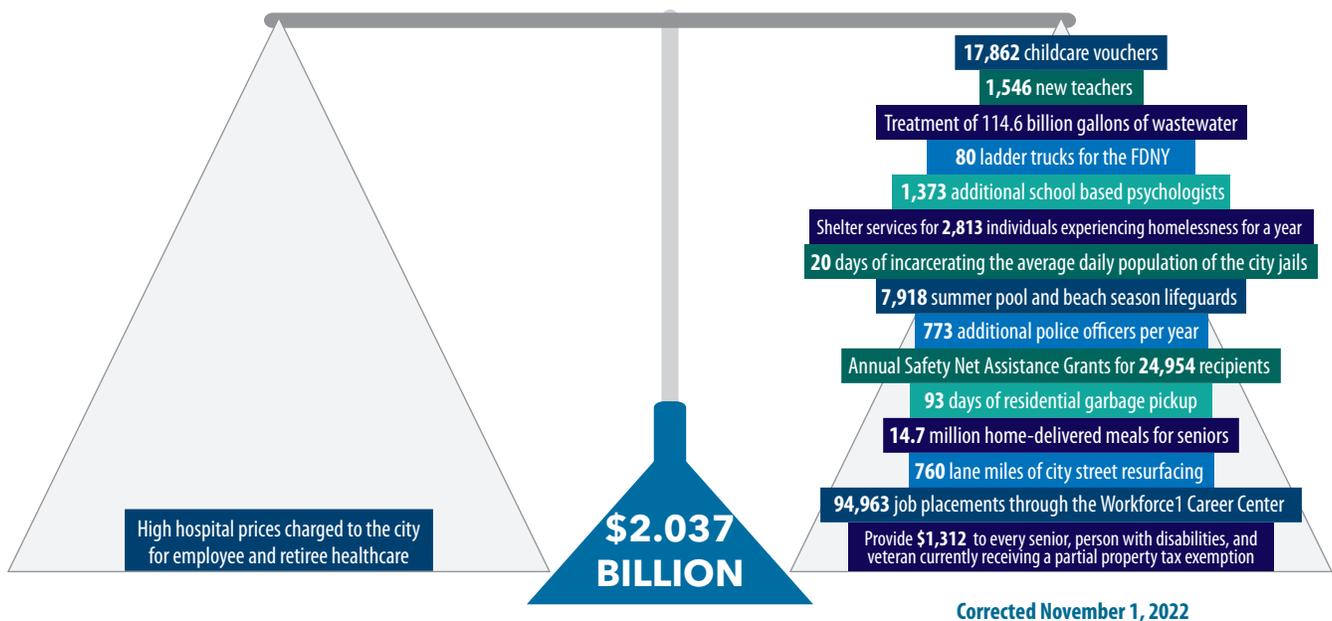
We're proud to be able to provide our members with protection from surprise and balance billing, and we are able to help them weather the worst of whatever health-related tragedy they are enduring. But maintaining our welfare fund and fighting for a comprehensive health plan in our large contracts means we lose out on wage increases. We want to do the best we possibly can for our members and that means finding a way to provide excellent healthcare without having to compromise potentially huge wage increases at the bargaining table.

**Dan Byers**, Organizer, UFCW Local 1500

## Impact to Public Budgets

Governments at the local and state level are among the largest purchasers of employee healthcare. According to information obtained by 32BJ Health Fund through Freedom of Information Law (FOIL) requests, as of October 2021, New York City purchased coverage for 606,000 active and retired employees at a total cost of \$9.007 billion.<sup>21</sup> At the beginning of 2015, there were 585,000 covered employees and retirees at a total cost of \$5.877 billion.<sup>22</sup> Taken together, these data indicate that during a roughly five-year period, New York City's spending on employee and retiree healthcare increased by more than 50 percent while the number of covered lives increased by only 4 percent. While the specific hospital prices charged to the city are not publicly available, the overall spending data illustrate the effects of hospital pricing on New York City's budget. An internal 2018 analysis, obtained through FOIL request from 32BJ Health Fund, showed that hospital inpatient prices increased at a rate of 7.1 percent per admission annually, while outpatient prices increased at a rate of 10.5 percent annually. Moreover, the city showed similar trends in price variation as those found in the Fund's analysis. For example, while the average citywide allowed cost per inpatient admission in 2018 was \$29,367, the same cost was \$40,748 at NewYork-Presbyterian; \$41,927 at Montefiore Medical Center; and \$39,371 at NYU Langone Health. These findings suggest a similar pattern of price variation as that identified in the Fund's analysis of its claims data.

If New York City's cost, utilization, and expenditure breakdown mirror statewide averages, then the city is paying \$2.037 billion above what Medicare would pay for the same services for New York City active and retired employees' healthcare.<sup>23</sup> The Independent Budget Office (IBO) refers to the city budget as a process of tradeoffs as "policymakers face a wide variety of choices about allocating resources in the context of competing budget priorities."<sup>24</sup> While it is not our intention to advocate for any particular budget item, the example below, taken from the IBO's projections, clearly demonstrates that high hospital prices charged to the city for employee and retiree healthcare, coupled with lucrative property tax benefits, do impose a steep cost on New York City taxpayers.



Finally, the property tax abatement granted to private hospitals further reduces the city budget as lost tax revenue. An analysis of publicly available city property tax data reveals that the five largest New York City hospital systems received an estimated \$363 million in property tax exemptions from the City of New York from 2020 to 2021.<sup>25</sup>

# DEBUNKING THE MYTHS ON WHY HOSPITALS CHARGE HIGH PRICES

Hospitals and trade organizations present a number of arguments throughout media and written literature as justification for why high prices are necessary. Below, we provide a summary of available evidence that debunks several commonly used arguments.

## Myth 1: Higher Prices are Needed to Offset Medicare, Medicaid, and Charity Care

One of the most popular reasons given by hospital trade organizations to justify high hospital prices is the concept known as cost shifting, or raising prices to offset the lower prices paid by government programs like Medicaid and Medicare. A recent nonpartisan analysis performed by the Congressional Budget Office found that, “[t]he share of providers’ patients who are covered by Medicare and Medicaid is not related to higher prices paid by commercial insurers.” Put simply, hospitals do not raise prices to offset the lower prices paid by government programs, nor are hospitals raising prices in order to offset increasing expenses.<sup>26</sup> It is not uncommon to hear from hospital trade groups that Medicare and Medicaid rates are not enough to sustain their business model when addressing public concerns about rising hospital prices. Yet, the Congressional Advisory Commission which sets reimbursement rates for Medicare (MedPAC) specifically calculates prices to cover around 8 percent more than hospitals’ allowed variable costs.<sup>27</sup> While 8 percent margin over actual cost may not be sufficient to sustain a high quality and financially viable non-profit hospital system, does this justify hospitals charging 200 to 350 percent of Medicare rates for the very same services?<sup>28</sup>

A New York State Health Foundation study looked at cost shifting in New York State and found that there was a correlation between price and public payer mix in the greater New York City area, though the correlation was negative.<sup>29</sup> In other words, the higher a hospital’s public payer mix, the lower its commercial prices. The same finding was observed when analyzing Medicaid payer mix alone.

Another common tactic is to point to “charity care,” defined as the care provided for free or at reduced prices to low-income individuals, to support hospital pricing strategy. In aggregate, non-profit hospitals spent \$2.30 of every \$100 in total expenses incurred on charity care, which was less than government (\$4.10) or for-profit (\$3.80) hospitals.<sup>30</sup> Results from a comprehensive study published in 2020 suggest that many non-profit hospitals’ charity care provisions were not aligned with their charity care obligations, primarily arising from their

### CASE STUDY

#### New York Presbyterian

Over the past two decades, New York Presbyterian (NYP) has reduced charity care spending and rolled back discounts provided to low-income patients. In a 2021 study by the Lown Institute, NYP received \$237 million more in tax breaks than it spent in community services. Only one hospital nationwide had a larger charity care deficit.<sup>35</sup>

The system has decreased its total charity care spending from \$70 million in 2004<sup>36</sup> to less than \$50 million in 2017.<sup>37</sup> Since that time, NYP has also eliminated charity care discounts for patients with incomes above 250 percent of the Federal Poverty Level, and reduced discounts for all but the very poorest patients.<sup>38</sup> In 2019, NYP paid its top 27 executives more than the total amount spent on charity care (\$55.25 million spent on salary and benefits, versus \$49.7 million on charity care).

favorable tax treatment.<sup>31</sup> Using Medicare cost report (MCR) data that is annually submitted by hospitals to the federal government, it appears that New York City non-profit hospitals' charity care program costs ranged from 0 to 2 percent of operating expenses,<sup>32</sup> while maintaining profit margins as high as 10 percent.<sup>33</sup>

Evidence suggests that hospitals do not need to engage in substantial cost shifting, nor do they actually engage in the type of cost shifting that would explain the higher prices paid for hospital services.<sup>34</sup> When hospitals and their trade associations point to charity care, uninsured payer mix, and the need to offset for Medicare and Medicaid populations, it is clear that these are unsupported by research and do not explain the continued rise in hospital prices.

### Myth 2: Consolidation Drives Down Prices

An increasing body of evidence points to the nationwide trend of growing hospital consolidation as a driving factor which gives hospitals increasingly strong market power relative to insurers.<sup>39</sup> Consequently, outsized market power allows hospitals to negotiate increasingly higher payment rates from private insurers, unrelated to how Medicare's payments compare to costs. This eases the financial pressure on these hospitals to cut prices or improve their efficiency. In 2020, MedPAC reviewed the published literature on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices."<sup>40</sup> An analysis of all hospital mergers over a five year period found that mergers of two hospitals within five miles of one another resulted in an average price increase of 6.2 percent and that price increases continued in the two years after a merger.

There have been multiple reports seeking to identify why hospital prices rise as a result of hospital consolidation. One oft-cited reason prices rise when there are hospital mergers is that they increase hospital bargaining positions with insurers, which seek to have large provider networks in order to attract employers with employees in multiple locations. Additionally, large hospital systems can influence negotiation dynamics with insurers and shift volume to higher cost facilities.

### CASE STUDY



Over the past five years, NYU Langone Health (NYU) has greatly expanded its geographic reach with the acquisition of acute care hospitals in Brooklyn, Nassau County, and Suffolk County, as well as the opening of a major new facility in Manhattan. In 2016, NYU acquired the 444-bed former Lutheran Medical Center in Brooklyn, an important safety net facility, and went on to acquire the 591-bed Winthrop University Hospital in Long Island in 2019. Using our claims data, 32BJ Health Fund observed that the prices at NYU increased year over year from 2016 to 2019, from 343 percent of Medicare on average in 2016, to 397 percent in 2019.

In July 2021, NYU announced its planned expansion into Suffolk County with the acquisition of the 306-bed Long Island Community Hospital, which was the last remaining independent hospital on Long Island.<sup>41</sup>

In a recent New York Times exposé, NYU's expansion was highlighted as an example of a hospital system using COVID-19 relief funds to sustain "big chains' spending spree as they expanded even more by scooping up weakened competitors and doctors' practices."<sup>42</sup> In response to criticism for using COVID-19 relief funds to grow its footprint, NYU responded in academic literature, mass media, and trade press by arguing that its growth strategy was designed to improve patient care and not drive profits.

### Myth 3: Higher Quality Deserves Higher Prices

In most consumer markets, higher prices generally imply increased quality. For example, in the automobile industry, higher pricing generally conveys a more complex or superior product. However, the price-to-quality connection is muddled in the healthcare industry, as information on both health prices and health quality can be difficult to obtain and interpret. There is research that debunks the myth that quality and price are causally or correlatively related.<sup>43</sup> Results of a large study conducted by the National Center for Biotechnology Information, a part of the National Institutes of Health and funded by the U.S. government, indicate that hospital prices are significantly and negatively associated with Total Performance Score, Patient Experience, and the Efficiency and Cost Reduction domains. Essentially, higher pricing compared to cost does not necessarily associate with higher quality and, in fact, might indicate the opposite.

While increasing, few authors to date have studied the relationship between hospital pricing and quality in the healthcare industry on a comprehensive basis. Those that have examined this area have focused on the variability in hospital pricing for standard procedures and a set of quality indicators, with one prominent study finding wide variation in charge-to-cost ratios with some hospitals charging as much as twelve times their own costs.<sup>44</sup> The New York State Health Foundation analyzed quality measures against relative price for New York health systems and observed that hospitals with higher prices did not necessarily have higher quality. Likewise, hospitals with lower prices did not necessarily have lower quality. High-priced care, and especially high-priced, low-quality care, creates an undue economic burden on those with the least capacity to pay.

### Myth 4: The COVID-19 Pandemic Impact to Hospital Budgets

There is no question that the COVID-19 pandemic has had enormous economic consequences across sectors, and health systems are no exception. However, hospital prices have been increasing beyond inflation since well before the COVID-19 pandemic. As a self-insured fund, 32BJ Health Fund has a unique ability to analyze participants' claims data and has seen that between 2016-2019 the Funds' annual medical spend increased from \$770 to \$930 million, with hospital payments rising from \$500 million to \$618 million.

#### CASE STUDY

### NYC HEALTH+ HOSPITALS

A partner in the 32BJ Health Fund Maternity Program, NYC Health + Hospitals/Elmhurst, has received designation as a Baby-Friendly birth facility from the World Health Organization and the United Nations Children's Fund for promoting the highest level of care for infants and mothers.<sup>45</sup>

Another partner, NYC Health + Hospitals/Metropolitan, has achieved excellent birth outcomes, with the lowest C-Section rate in Manhattan, a noteworthy midwifery program, and doula care available to 32BJ patients at no cost to them.<sup>46</sup>

As shown in Figure 2A in this report, the price of vaginal delivery or C-section observed by 32BJ Health Fund at NYC Health + Hospitals was one quarter to half the price when compared to most other hospitals in the greater New York City area.

Moreover, despite increased spending on care during the pandemic, hospital systems have largely emerged financially unscathed. At the onset of the COVID-19 pandemic, billions of dollars in government aid flowed through hospital systems, effectively maintaining or improving providers' financial performance in 2020.<sup>47</sup> The pandemic has been a period of growth for hospital systems who continue to pursue market consolidation by buying up competition and expanding their provider networks.

### CASE STUDY



Northwell Health received \$3.18 billion in Covid-related government assistance, including \$2.18 billion in grants and \$1 billion in loans.<sup>48</sup> The system received more COVID-19 grant funding than any other New York City system, exceeding even the \$2.06 billion received by New York City's safety net system - NYC Health + Hospitals. This has allowed Northwell Health to maintain a profitable operating margin throughout the pandemic, as shown in Figure 3 below.<sup>49</sup> Despite COVID-19's impact, the system's assets have increased 86 percent from 2016 to 2021.



**Figure 3.** Northwell Health Cash and Investments, Annual Financial Statements 2016-2020 and September 2021 quarterly update.

# THE PATH FORWARD: INTERVENTIONS TO BRING DOWN HOSPITAL PRICES

As we have shown through 32BJ Health Fund data and other research, hospital prices are the main driver of our costs and U.S. healthcare spending - findings that should direct policy change going forward to ensure the longevity of our health fund and similar plans. While there is no shortage of evidence pointing to high hospital prices as the leading cause of increased spending,<sup>50</sup> there are a wide array of hopeful strategies being pursued to lower hospital prices in the market. Some have worked to lower commercial hospital prices by enacting a cap on outlier prices through state and federal policymaking, while others have pursued more robust oversight by the Federal Trade Commission on anti-competitive practices of hospitals resulting from horizontal and vertical supply chain consolidation, and still others look at benefit design options to shift utilization toward high-value providers.



Given 32BJ Health Fund's critical interest in addressing this issue for our participants we will provide a brief summary of the following strategies that 32BJ Health Fund is using and exploring to lower hospital prices:

- + Benefit Design Options
- + Aggregated Purchasing Coalitions
- + Legislative and Regulatory Action
  - Anti-competitive Behavior
  - Non-profit Status
  - Rate-setting and Global Budgets

## Benefit Design Options

32BJ Health Fund continually assesses provider performance and incentivizes the use of high-value care that helps keep costs low. This allows us to maintain the fiscal sustainability of our health benefits without shifting more costs to participants each year. In the past decade, 32BJ Health Fund has implemented several benefit design changes aimed at moving participants toward high-value providers:

### Preferred Hospital Network

Using our own pricing data, 32BJ Health Fund assessed the wide price variation in the New York City market and created a tiered network of preferred and non-preferred hospitals. Hospitals could be considered "preferred" if they met requirements based on price, quality, and geographic access. To help encourage patients to use preferred hospitals for planned, non-emergency care, 32BJ Health Fund assigned lower copays for preferred hospitals and higher copays for non-preferred hospitals.

### Centers of Excellence (COEs)

32BJ Health Fund originally created “Centers of Excellence” programs for procedures like total joint replacement and bariatric surgery in the New York City area. We have recently expanded to a more geographically diverse set of provider partners in 2022. The Fund provides these surgeries at no cost to Fund participants through a partnership with Mount Sinai Health System and other affordable and high-quality partner hospitals in New Jersey, Connecticut, Florida, Massachusetts, and Pennsylvania. The program includes no copays for all visits from surgery through 30 days post-treatment, access to high-quality surgeons, personal care guides to answer questions and coordinate visits, and free transportation to and from surgery.

### Maternity Program

After analyzing our maternity care data and finding high rates of complications, and overuse of episiotomies and C-sections, 32BJ Health Fund wanted to improve the quality of maternity care for its plan participants. Using a data-driven, custom-built Request for Information (RFI), the Health Fund identified eight high-value hospitals and developed a benefits program to encourage maternity patients to use these providers. Mothers who participate in the program are able to give birth for no more than a single \$40 copay for standard maternity care, from the first maternity visit to birth and postpartum checkup.



Despite all 32BJ Health Fund has done to move participants toward high-quality, affordable providers, we recognize that benefit design changes alone do not solve the fundamental issue of high prices, and cannot be the only solution for bending the healthcare cost curve. These efforts must be complemented by alignment with other purchasers, and further supported by regulatory and legislative action.

### Aggregated Purchasing Coalitions<sup>51</sup>

Forming an aggregated purchasing coalition (APC) in the New York City market may be one viable solution for controlling high hospital prices. Aggregated purchasing refers to the amassing of lives across multiple purchasers to collectively procure healthcare services through direct negotiations with healthcare providers. It can also refer to the procurement of other related health services such as pharmacy benefits, data analysis, or discounted administrative fees.

As an example, Peak Health Alliance was formed in 2019 as a healthcare purchasing cooperative in Colorado, who now offers community-driven plan designs for participants in eight counties of the state. In combination with intense community pressure, Peak used Medicare reference pricing data to negotiate direct contracts and new fee schedules with area hospitals.<sup>52</sup> As a result, Peak participants have seen a premium savings of nearly 50 percent from 2019 to 2022.<sup>53</sup>

There are numerous ways in which an APC can be deployed in the market. Given the successes and failures of other aggregate purchasing attempts, the following are best practices, courtesy of Catalyst for Payment Reform’s research: (1) be prepared for prolonged and uncomfortable discussions with healthcare providers as they are presented with data demonstrating pricing distortions within hospitals and health systems; (2) full alignment between the APC group and its constituent leadership (i.e., board of trustees, C-suite, public chief of staff, etc.); and (3) engage in proactive member education campaigns, early and often, in an effort to prepare participants for the future and communicate benefits and overall strategy. Because the New York City government serves as such a large purchaser, along with significant union funds such as 32BJ Health Fund, there may be significant opportunities for alignment and collective impact within the New York City market.

Further research performed by Catalyst for Payment Reform found that there is tremendous “opportunity for collaboration when conversations occur directly between employers and providers rather than by proxy. . . [t]he commonality between employers and providers is their roots in their communities and their shared accountability for the health and well-being of individuals and families, which can – in many instances – outweigh the impulse to focus exclusively on revenues and profit margin.” Indeed, the value of employer-driven aggregated purchasing includes opportunities for innovation in payment model and access, “which result in better clinical and experiential outcomes for patients.”

## Legislative and Regulatory Action

Changing the purchasing model is an “inside out” approach that 32BJ Health Fund firmly believes can help deliver better value. However, there also exists a need to advocate for change “from the outside in” by working with federal, state, and local regulators to more closely monitor and counteract the anti-competitive forces at play in the healthcare market.



## Anti-competitive Behavior

Efforts to combat the negative effects of consolidation on competition are occurring at local, state, and federal levels with varied success. The Federal Trade Commission (FTC) has the ultimate antitrust authority to block anti-competitive mergers and acquisitions. After a period of very little enforcement, the FTC has recently had some success in challenging and ultimately blocking horizontal mergers among hospital systems operating in the same region, but these efforts are largely insufficient on their own to reduce high hospital prices.<sup>54</sup> At the federal level, meaningful antitrust scrutiny of anti-

competitive behavior, assertive merger control, and research on non-price competitive effects of healthcare mergers offer some means of addressing hospital market consolidation. While there seems to be much discussion centered on antitrust in healthcare, most experts recognize that these cases can take years to play out in the courts and therefore cannot be the sole hope to address an urgent crisis.

Contracting between health plans and providers is another opportunity for addressing anti-competitive behavior. For example, hospital systems may require that insurers include all hospitals in their system in a provider network if the insurer wants any hospitals included. This contracting practice has been the subject of two antitrust lawsuits against Sutter Health, both of which

allege Sutter violated California’s antitrust laws by using its market power to illegally drive up prices.<sup>55</sup> The first lawsuit resulted in a 2019 settlement, which prohibited Sutter from using an “all or nothing” approach that would require all of its hospitals be included in an insurer’s network. To help states with these efforts, the National Academy for State Health Policy has developed model legislative language for states to use in order to prohibit widespread anti-competitive, consolidated market concerns.<sup>56</sup> 32BJ Health Fund and the sponsors and supporters of the HEAL Act would like this same flexibility in network structure in New York State.

The Hospital Equity and Affordability Law, or HEAL Act, seeks to bar hospitals from striking contracting deals with insurers that have the effect of raising hospital prices. The HEAL Act was inspired, in part, by the maternity program created by 32BJ Health Fund, which has been lauded as a first-of-its-kind program. 32BJ Health Fund offers high-quality prenatal, delivery, and post-natal care at partner hospitals at no to low out-of-pocket cost. A 2021 contract between Empire Blue Cross Blue Shield and NewYork-Presbyterian would have forced the Fund to end the innovative programs it currently offers participants, including the maternity program.<sup>57</sup> The HEAL Act (S7199-A8169) currently sits in the Insurance Committee in both the Senate and Assembly of New York.

### Ensure that Hospitals Deliver on Their Non-Profit Status

Decades ago, the federal government created rules excepting non-profit hospitals from many taxes, as hospitals relied upon philanthropy—the support of religious organizations or the generosity of individual donors—to balance their budgets. Today, the large private hospital systems that dominate the New York City market, and others, hold assets of billions of dollars, including endowments and for-profit subsidiaries. At the same time, they are still granted valuable tax exemptions for their property and real estate holdings. As documented above, in New York City alone, these exemptions are costing New York City taxpayers over \$363 million per year. The traditional reasons given for this public largesse is that hospitals provide significant amounts of charitable care and community benefits while serving as a public good. However, with an ever-dwindling amount of hospital budgets going to charity care, state legislatures and courts have begun to question whether large private hospital systems truly merit large tax exemptions.



States have a variety of legislative and regulatory levers at their disposal, including the ability to require a hospital’s minimum spending amount on community benefit. An analysis of over 2,400 hospitals that submitted IRS Form 990 from 2009 to 2015, including Schedule H, found that there was an increase in community benefit spending on community health initiatives in states with minimum spending amounts.<sup>58</sup> The following are examples of states that legislate community benefit spending amounts and reporting requirements:

- + Illinois law requires non-profit hospitals to spend the amount of their property tax on “services that address the healthcare needs of low-income or underserved individuals or relieve the burden of government with regard to healthcare services” in order to receive a property tax exemption.

- + In Nevada, non-profit hospitals with more than 100 beds in counties with two or more hospitals are required to report “the expenses that the hospital has incurred for providing community benefits and the in-kind services that the hospital has provided to the community in which it is located.” They are also required to provide 0.6 percent of the previous fiscal year’s revenue in indigent care.
- + In 2019, Oregon passed HB 3076 to expand income limits for charity care and create a community benefit spending floor for Oregon’s non-profit hospitals. The bill reduces the cost of care to zero for individuals earning less than 200 percent of the federal poverty level (FPL) and creates a sliding scale for those earning 200 to 400 percent of FPL.

Similarly, courts, Attorneys General, and tax review boards can and are assessing whether hospitals’ behavior truly merit generous tax exemption. In Illinois, the state Supreme Court upheld the revocation of tax exemptions for Provena Covenant Medical Center based on low amounts of charity care, out-sourcing of services to for profit entities, and referring patients to collection agencies for unpaid bills.<sup>59</sup> More recently, Pennsylvania Courts upheld the revocation of the non-profit exemptions for Brandywine, Phoenixville, and Jennersville hospitals, all held by Tower Health. The court cited profit seeking behavior as a key reason for revoking non-profit status, including compensation bonuses tied to financial performance.



In 2019, Northwell Health admitted guilt and paid a \$12.3 million settlement for filing false claims. The doctor at the center of the case was hired based on projections of the revenue he could bring the hospital system and his compensation included bonuses tied to revenue he brought in.<sup>60</sup> New York regulatory entities could explore whether continued taxpayer subsidies of private hospital networks is merited should their actions continue to prioritize hospital revenue over charity and community care.

### Rate Setting and Global Budgets

Other states have broader policies to control health spending. Maryland, for example, has a waiver from CMS to use an all-payer model which establishes uniform payment rates on a global budget basis that Medicare, Medicaid, and commercial insurers must pay. The final evaluation report for Maryland’s program showed reductions in hospital spending for both Medicare beneficiaries and private plan participants.<sup>61</sup> Commercial insurance had 6.1 percent slower growth in total hospital expenditures.<sup>62</sup> Rhode Island also imposed inflation price controls on hospital spending paired with payment increases for primary care, resulting in lower healthcare spending for commercially insured adults.<sup>63</sup>

Further, certain states have begun to leverage their purchasing power to implement spending controls. Montana, Oregon, Washington, and Colorado, have implemented or are considering approaches that would cap payment for hospital services at a percentage of Medicare for state employee health plans or public options, with payment rates ranging from 182 to 234 percent of local Medicare reimbursement rates.<sup>64</sup>

Last, we recognize that transparency in healthcare pricing is essential, but do not think that it is the “silver bullet” solution to controlling high hospital prices. Price transparency, and the use of all-payer claims databases, are key to understanding the wide price differences that exist in a given healthcare market. However, this work cannot occur in lieu of meaningful efforts to decrease hospital prices and control healthcare spending through regulatory and legislative action.

# CONCLUSION

The 32BJ Health Fund is committed to providing high-quality and affordable healthcare for our participants and their families. Our mission is threatened by the ever-increasing cost of providing healthcare. In looking at our own claims data we were able to determine that the most significant threat to the longevity of our benefit is high hospital prices. As we began to look at the issue, we first looked at the impact to the Fund. We found that: the high prices charged by hospitals led to significant costs to our fund (the Fund paid \$1.1 billion above Medicare prices from 2016-2019); there was wide variation in price for common procedures across hospital systems; and these prices had a direct negative impact on the wages of our participants. Our conclusions match the overwhelming consensus in the research literature: commercial insurers pay much higher prices for hospital services than Medicare and these prices are much higher than hospitals' expenses. These higher prices result in increased premiums, greater cost-sharing requirements for patients, reduction in the scope of benefits to members, and increased federal government subsidies for healthcare.



Within this paper, 32BJ Health Fund examined the reasons frequently given by hospitals to justify their higher prices, including the need to subsidize public or charity care, provision of higher quality care, and the impact of COVID-19 to hospital financials. In each case, we found that these reasons fail to withstand objective scrutiny. Moreover, we found that consolidation does not drive down prices for consumers; in fact the opposite is often true. Recognizing that benefit design alone will not combat the impact of high hospital prices on our fund, we examined possible solutions based on public and government action. Potentially viable options included aggregated purchasing coalitions, restricting anti-competitive contracting practices, reviewing the non-profit status of large, private hospital systems, and exploring rate regulation and global budgets.

We know there is no "one size fits all" solution to this problem, but we believe that by partnering with union leadership, employers, our elected officials and appointees, and the greater healthcare provider community we will be able to find equitable and sustainable solutions to the problem of high hospital prices. Finding a solution will allow the Fund, and similar purchasers, to continue to provide the high quality healthcare our participants have come to expect.

# APPENDIX

PROCEDURE	NYP	NYU	Northwell	MSHS	Montefiore	Maimonides	NYC H+H	Mass Gen/Brigham	Boston Med Center	Cambridge Health Alliance
Angioplasty	\$58,291	\$56,549	\$71,680	—	\$75,178	—	—	—	—	—
Bariatric Surgery	—	\$52,980	—	\$42,157	\$60,481	\$41,055	—	—	\$29,881	—
CABG / Valve Proc	—	\$224,887	\$196,624	\$171,260	—	—	—	—	—	—
Colorectal Resection	\$88,120	\$75,953	\$57,908	\$53,017	—	—	—	—	—	—
C-Section	\$45,602	\$40,568	\$33,025	\$30,175	\$55,077	\$27,716	\$17,861	—	\$27,467	\$19,778
Lumbar Spine Fusion	\$252,464	\$227,949	—	\$154,375	—	—	—	—	—	—
Gall Bladder Surgery	\$66,594	—	—	—	\$50,646	—	—	—	—	—
Hip Replace / Revision	—	\$85,133	\$80,885	\$56,002	—	—	—	—	—	—
Hysterectomy	\$42,818	\$33,398	—	\$32,920	\$51,377	\$31,435	—	—	—	—
Knee Replace / Revision	—	\$63,853	\$85,498	\$57,718	\$90,184	—	—	—	—	—
Lung Resection	—	\$71,744	\$66,787	\$69,672	—	—	—	—	—	—
Mastectomy	—	\$44,957	\$61,688	\$71,335	\$85,353	—	—	—	—	—
Prostatectomy	\$55,211	—	\$54,628	\$44,378	\$71,922	\$51,019	—	—	—	—
Vaginal Delivery	\$33,729	\$25,900	\$24,233	\$22,774	\$41,740	—	\$11,101	\$16,526	\$12,202	\$10,796

**Table 1.** 32BJ Health Fund **Inpatient** Procedure Average Aggregate Price by System, 2019-2021.

Missing columns indicate there was not enough data available to calculate reliable results.

PROCEDURE	NYP	NYU	Northwell	MSHS	Montefiore	Maimonides	NYC H+H	Mass Gen/Brigham	Boston Med Center	Cambridge Health Alliance
Angioplasty	\$60,142	\$57,287	\$70,100	—	\$20,275	\$35,012	—	—	—	—
Breast Biopsy	—	—	\$4,921	\$6,108	\$8,674	—	\$3,363	\$4,242	\$2,446	—
Cataract Surgery	\$12,893	\$18,144	\$9,377	\$6,454	\$12,041	—	\$4,245	\$4,363	—	—
Colonoscopy	\$10,368	\$9,447	\$4,445	\$4,139	\$6,514	\$6,517	\$2,185	\$2,962	\$1,945	\$2,522
Upper GI Endoscopy	—	\$8,849	\$4,773	---	\$5,446	\$4,991	\$1,964	\$2,724	\$1,842	\$2,695
Gall Bladder Surgery	\$13,352	\$19,198	\$19,039	\$9,509	\$13,478	\$10,885	\$4,594	—	\$8,611	—
Hysterectomy	\$22,622	\$23,647	\$24,348	\$11,422	\$22,493	—	—	—	\$13,591	—
Knee Replace/Revision	—	\$26,393	—	\$22,456	—	—	—	—	—	—
Lumbar Laminectomy	\$18,159	\$24,183	—	\$15,193	\$20,579	—	—	—	—	—
Mastectomy	\$15,362	\$20,505	—	\$11,367	\$10,198	\$9,466	—	—	—	—
Pacemaker / Defib	—	\$26,938	—	\$36,081	—	\$35,260	—	—	—	—
Tonsillectomy	—	\$12,454	\$10,316	\$7,487	\$11,356	—	—	—	—	—
Transurethral Resection Prostate	\$14,873	\$25,285	\$12,436	\$8,462	—	—	—	—	—	—

**Table 2.** 32BJ Health Fund **Outpatient** Procedure Average Aggregate Price by System, 2019-2021.

Missing columns indicate there was not enough data available to calculate reliable results.

Previous versions of the paper included a print error mislabeling hospital outpatient procedures in Table 2

# ENDNOTES

1. Corrected November 1, 2022
2. Hartman M, Martin AB, Washington B, Catlin A, The National Health Expenditure Accounts Team. National Health Care Spending In 2020: Growth Driven By Federal Spending In Response To The COVID-19 Pandemic: National Health Expenditures study examines US health care spending in 2020. *Health Affairs*. 2022;41(1):13-25. doi:10.1377/hlthaff.2021.01763
3. Sisko AM, Keehan SP, Poisal JA, et al. National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth. *Health Affairs*. 2019;38(3):491-501. doi:10.1377/hlthaff.2018.05499
4. Claxton G, Damico A, Rae M, Young G, McDermott D, Whitmore H. Health Benefits In 2020: Premiums In Employer-Sponsored Plans Grow 4 Percent; Employers Consider Responses To Pandemic: The annual Kaiser Family Foundation Employer Health Benefits Survey of the cost and coverage of US employer-sponsored health benefits. *Health Affairs*. 2020;39(11):2018-2028. doi:10.1377/hlthaff.2020.01569
5. Report to Congress: Medicare Payment Policy. MedPAC; 2019. Accessed March 10, 2022. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar19\\_medpac\\_entirereport\\_sec\\_rev.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf)
6. Whaley CM, Briscoe B, Kerber R, O'Neill B, Kofner A. Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. RAND Corporation; 2020. Accessed March 8, 2022. [https://www.rand.org/pubs/research\\_reports/RR4394.html](https://www.rand.org/pubs/research_reports/RR4394.html)
7. Private systems in New York City include NewYork-Presbyterian, NYU Langone Health, Mount Sinai Health System, Northwell
8. Corrected November 1, 2022
9. Corrected November 1, 2022
10. Corrected November 1, 2022
11. White C, Whaley CM. Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely. RAND Corporation; 2021. Accessed March 10, 2022. <https://www.rand.org/pubs/periodicals/health-quarterly/issues/v9/n2/05.html>
12. Claims data include utilization across New York State, Connecticut, Massachusetts, New Jersey, and Pennsylvania. A majority of 32BH Health Fund expenditures were incurred in New York City (\$1.3 billion).
13. To identify outlier costs by procedure and system, the interquartile range (IQR) 1.5 was applied. After removing outliers, the skewness of the distribution for each procedure and system was measured, and omitted for non-symmetrical distributions where skew was above 1 or less than -1. After removing outliers and omitting skewed data, the mean and median are expected to be similar. If they were not, this suggests that data still had non-normal distribution where average cost is difficult to calculate. If mean and median differed by more than 15 percent for a given procedure, it was omitted.
14. Muoio D. Health cost regulator tells Mass General Brigham to clamp down on spending, critiques \$2B expansion plan. *Fierce Healthcare*. <https://www.fiercehealthcare.com/hospitals/mass-general-brigham-mgb-massachusetts-cost-spending>. Published January 26, 2022. Accessed March 8, 2022.
15. Gorman Actuarial, Inc. Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement. New York State Health Foundation; 2016. Accessed March 8, 2022. <https://nyshealthfoundation.org/wp-content/uploads/2017/11/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf>
16. In this study, “high-price” hospitals were those whose median commercial negotiated prices were in the top 10th percentile of the 1,225 hospitals assessed nationwide.
17. The Prices That Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services. Congressional Budget Office; 2022. <https://www.cbo.gov/publication/57422>
18. Cutler D. The World’s Costliest Health Care. *Harvard Magazine*. Published online April 10, 2020. Accessed March 8, 2022. <https://www.harvardmagazine.com/2020/05/feature-forum-costliest-health-care>
19. Employer-sponsored health insurance costs rose sharply in 2021, outlook for 2022 is uncertain | Mercer. Mercer. Published December 2021. Accessed March 8, 2022. <https://www.mercer.us/newsroom/employer-sponsored-health-insurance-cost-rose-sharply-in-2021-outlook-for-2022-is-uncertain.html>
20. Stokes M, 2021. Americans’ Challenges with Health Care Costs. KFF. Published December 14, 2021. Accessed March 8, 2022. <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>

- 21.** Corrected November 1, 2022
- 22.** Corrected November 1, 2022
- 23.** Corrected November 1, 2022. Total city cost was \$9.007 billion billion for 2021. Research from Health Affairs estimates that 39 percent of health care spending in New York is on hospital services. Assuming an equivalent percentage for the city, this would correlate to \$3.51 billion. 32BJ Health Fund found that for its hospital prices, the Fund was paying 240 percent of Medicare. If the same were true of the city, then the city would be paying \$2.037 billion above Medicare prices on hospital services. Health Affairs Citation: Fraction of Personal Total 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>
- 24.** Understanding New York City's Budget: A Guide. New York City Independent Budget Office; 2021. <https://www.ibo.nyc.ny.us/iboreports/understandingthebudget.pdf>
- 25.** From internal analysis of publicly available tax exemption documents from New York City.
- 26.** "Stating that in addition to increased market consolidation as a leading factor in increase price, "... the prices that commercial insurers pay hospitals are much higher than hospitals' costs."
- 27.** Report to Congress: Chapter 3 - Hospital Inpatient and Outpatient Services. MedPAC; 2019. Accessed March 10, 2022. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar19\\_medpac\\_ch3\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch3_sec.pdf)
- 28.** "If hospitals were able to cost shift, then hospitals with larger shares of Medicare and Medicaid patients (for whom prices are relatively low) would be paid relatively high prices by commercial insurers. However, CBO's analysis of data for more than 1,500 hospitals indicates a weak cross-sectional relationship between commercial insurers' average prices for a hospital's inpatient and outpatient services during the 2016–2018 period and the percentage of Medicare and Medicaid patients among the hospital's discharges."
- 29.** Public payers are defined as Medicaid and Medicare collectively.
- 30.** Bai G, Zare H, Eisenberg MD, Polsky D, Anderson GF. Analysis Suggests Government And Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment: Study examines government and nonprofit hospital charity care expenses compared to charity care obligations arising from the organizations' favorable tax treatment. *Health Affairs*. 2021;40(4):629-636. doi:10.1377/hlthaff.2020.01627
- 31.** Bai G, Yehia F, Anderson GF. Charity Care Provision by US Non-profit Hospitals. *JAMA Intern Med*. 2020;180(4):606. doi:10.1001/jamainternmed.2019.7415
- 32.** How to Complete NASHP's Hospital Cost Tool. The National Academy for State Health Policy. Published September 28, 2020. Accessed March 10, 2022. <https://www.nashp.org/how-to-complete-nashps-hospital-cost-tool/>
- 33.** Fitch Affirms New York and Presbyterian Hospital (NY) Revs at "AA"; Outlook Stable. Fitch Ratings. Published August 2, 2021. <https://www.fitchratings.com/research/us-public-finance/fitch-affirms-new-york-presbyterian-hospital-ny-revs-at-aa-outlook-stable-02-08-2021>
- 34.** Frakt AB. How Much Do Hospitals Cost Shift? A Review of the Evidence: How Much Do Hospitals Cost Shift? *Milbank Quarterly*. 2011;89(1):90-130. doi:10.1111/j.1468-0009.2011.00621.x
- 35.** Garber J. The 41 hospitals costing communities \$4 billion. *Lown Institute Hospital Index*. Published August 5, 2021. Accessed March 10, 2022. <https://lownhospitalsindex.org/publication/the-41-hospitals-costing-communities-4-billion/>
- 36.** Gaynor M. Examining the Impact of Health Care Consolidation. Presented at: U.S House of Representatives; February 14, 2018; Submission before the Committee on Energy and Commerce Oversight and Investigations Subcommittee
- 37.** NEW YORK AND PRESBYTERIAN HOSPITAL - Form 990. IRS; 2019. Accessed March 10, 2022. [https://projects.propublica.org/nonprofits/display\\_990/133957095/03\\_2021\\_prefixes\\_11-16%2F133957095\\_201912\\_990\\_2021030117772013](https://projects.propublica.org/nonprofits/display_990/133957095/03_2021_prefixes_11-16%2F133957095_201912_990_2021030117772013)
- 38.** NEW YORK AND PRESBYTERIAN HOSPITAL - Form 990. IRS; 2016. Accessed March 10, 2022. [https://projects.propublica.org/nonprofits/display\\_990/133957095/01\\_2018\\_prefixes\\_13-14%2F133957095\\_201612\\_990\\_2018010315074900](https://projects.propublica.org/nonprofits/display_990/133957095/01_2018_prefixes_13-14%2F133957095_201612_990_2018010315074900)
- 39.** Cost Shift Analysis Report. Colorado Healthcare Affordability & Sustainability Enterprise; 2019. <https://colohealthplans.org/cost-shift-analysis-report/>
- 40.** Report to the Congress: Medicare Payment Policy. MedPAC; 2020:470. [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar20\\_entirereport\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf)
- 41.** Sim S. NYU Langone and Long Island Community Hospital

merger receives Health Department approval | Modern Healthcare. Modern Healthcare. Published November 23, 2021. Accessed March 8, 2022. <https://www.modernhealthcare.com/mergers-acquisitions/nyu-lan-gone-and-long-island-community-hospital-merger-receives-health>

**42.** Abelson R. Big Hospital Chains Get Covid Aid, and Buy Up Competitors - The New York Times. New York Times. <https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html>. Published May 21, 2021. Accessed March 8, 2022.

**43.** Beauvais B, Gilson G, Schwab S, Jaccaud B, Pearce T, Holmes T. Overpriced? Are Hospital Prices Associated with the Quality of Care? *Healthcare*. 2020;8(2):135. doi:10.3390/healthcare8020135

**44.** Bai G, Anderson GF. Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios. *Health Affairs*. 2015;34(6):922-928. doi:10.1377/hlthaff.2014.1414

**45.** NYC Health + Hospitals/Elmhurst Earns Baby Friendly Status. NYC Health + Hospitals. Published April 5, 2019. Accessed March 10, 2022. <https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-elmhurst-earns-baby-friendly-status/>

**46.** 32BJ Health Fund Maternity Flyer. Accessed March 10, 2022. [https://health.32bjfunds.org/portals/1/PDFs/VM\\_Trifold\\_ENG.pdf](https://health.32bjfunds.org/portals/1/PDFs/VM_Trifold_ENG.pdf)

**47.** Ochieng N, Fuglesten Biniek J, Muscumeci MB, Neuman T. Funding for Health Care Providers During the Pandemic: An Update | KFF. KFF. Published January 27, 2022. Accessed March 8, 2022. <https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/>

**48.** Top 100 Parent Companies for Total Grants. Covid Stimulus Watch: Good Jobs First. Accessed March 8, 2022. <https://data.covidstimuluswatch.org/top-100-parents>

**49.** Ernst & Young LLP. Consolidated Financial Statements and Supplementary Information. Northwell Health, Inc; 2016. <https://www.northwell.edu/about-northwell/financial-health-annual-reports>

**50.** Cooper Z, Craig S, Gaynor M, Harish NJ, Krumholz HM, Van Reenen J. Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14. *Health Affairs*. 2019;38(2):184-189. doi:10.1377/hlthaff.2018.05424

**51.** Aggregated Purchasing of Health Care Services: Lessons Learned and Blueprints for Success. Catalyst for Payment Reform; 2021. [\[loads/2021/05/Full-Report-Aggregated-Purchasing\\\_Published\\\_May-2021-fljkrq.pdf\]\(https://www.catalyze.org/wp-content/uploads/woocommerce\_uploads/2021/05/Full-Report-Aggregated-Purchasing\_Published\_May-2021-fljkrq.pdf\)](https://www.catalyze.org/wp-content/uploads/woocommerce_up-</a></p></div><div data-bbox=)

**52.** Unlocking the Power of the All Payer Claims Database – Use Cases from Colorado. Catalyst for Payment Reform. Published October 18, 2021. Accessed March 10, 2022. <https://www.catalyze.org/unlock-the-power-of-apcds/>

**53.** Summit in Sight: Peak Health Alliance Targets High Prices in Trailblazing Effort. Colorado Health Institute; 2019. Accessed March 9, 2022. <https://www.coloradohealthinstitute.org/research/peak-health-alliance-summit-sight>

**54.** Capping Hospital Prices: Health Savers Initiative. Committee For a Responsible Federal Budget; 2021. Accessed March 9, 2022. [https://www.crfb.org/sites/default/files/managed/media-documents2022-02/HSI\\_CappingHospitalPrices.pdf](https://www.crfb.org/sites/default/files/managed/media-documents2022-02/HSI_CappingHospitalPrices.pdf)

**55.** Press A. Class-Action Lawsuit With 3 Million Plaintiffs Seeks \$1.2B From Sutter Health. CBS Local. <https://sanfrancisco.cbslocal.com/2022/02/10/sutter-health-antitrust-class-action-lawsuit-with-3-million-plaintiffs/>. Published February 10, 2022. Accessed March 9, 2022.

**56.** Gudiksen KL, Brown ECF, Butler J. A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts. *National Academy for State Health Policy*; 2021:6.

**57.** 32BJ HEALTH FUND SEVERES TIES WITH NEWYORK-PRESBYTERIAN. 32BJ Health Fund. Published June 2021. Accessed March 9, 2022. <https://www.32bjHealthFundInsights.org/index.php/2021/06/03/32bj-health-fund-severs-ties-with-newyork-presbyterian/>

**58.** Atkeson A, Higgins E. How States Can Hold Hospitals Accountable for their Community Benefit Expenditures. *The National Academy for State Health Policy*. Published March 15, 2021. Accessed March 9, 2022. <https://www.nashp.org/states-can-hold-hospitals-accountable-for-their-community-benefit-expenditures/>

**59.** Serbaroli FJ. More Non-Profit Hospitals Lose Property Tax-Exemptions. *New York Law Journal*. Published online January 21, 2022. Accessed March 9, 2022. <https://www.law.com/newyorklawjournal/2022/01/21/more-non-profit-hospitals-lose-property-tax-exemptions/>

**60.** Manhattan U.S. Attorney Announces \$12.3 Million Settlement With Lenox Hill Hospital For Submitting Fraudulent Medicare Claims For Urology Procedures And Hospital Services.; 2019. Accessed March 9, 2022. <https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-123-million-settlement-lenox-hill-hospital-submitting>

- 61.** Haber S, Beil H, Morrison M, et al. EVALUATION OF THE MARYLAND ALL-PAYER MODEL VOLUME II: FINAL REPORT APPENDICES. RTI International for CMS. Published online November 2019:552.
- 62.** Maryland All-Payer Model Final Evaluation Report (2014-2018). Center for Medicare & Medicaid Services Accessed March 10, 2022. <https://innovation.cms.gov/files/reports/md-allpayer-finalevalrpt-fg.pdf>
- 63.** Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. 2019;38(2):237-245. doi:10.1377/hlthaff.2018.05164
- 64.** Gustafsson L, McIntosh A. States' Role in Combatting High Health Care Prices. doi:10.26099/k2p3-6h57



**25 WEST 18<sup>TH</sup> STREET  
NEW YORK, NY 10011-4676**

**[healthfund@32bjfunds.com](mailto:healthfund@32bjfunds.com) · [32bjhealthfundinsights.org](http://32bjhealthfundinsights.org)**