Testimony of
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55 W. 125th Street, Room 524
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Hearing on the New York Health Act
Before the
NY State Senate
Legislative Office Building Hearing Room A, 2nd Floor.
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Thank you for the opportunity to comment on the New York Health Act. I am an Associate Professor of Health Policy and Management at the CUNY School of Public Health located in Harlem, New York. I am also a Lecturer at the Krieger School of Arts & Sciences at the Johns Hopkins University and the chair-elect of the Law Section of the American Public Health Association.

As a professor, I study the means to advance public health through better policy. My recent work focuses on price transparency and what I call "financial informed consent:"[1] the concept that patients and their families should be given the opportunity to consider costs when making medical decisions should they want that information.[2]

[1] Elizabeth Geltman*, Cost Needs to Be Part of the Medical Informed Consent Process,* HuffPost (Dec 8, 2016) ,https://www.huffpost.com/entry/cost-needs-to-be-part-of-the-medical-informed-consent-process_b_8742926

[2] E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. Legal Med. 275, 291 (1991).

Two thirds of bankruptcies in the United States result from medical bills.[3] A study led by my CUNY colleague Dr. David Himmelstein found that about 530,000 families are financially ruined each year by medical bills.[4]

A large percentage of medical costs result from health providers practicing "defensive medicine"[5] and "balance billing."[6] No restaurant would stay in business if patrons were required to sign a blank check and allow the wait staff to serve whatever they think the patron should eat without even considering the costs of items served. Yet everybody who walks into a health provider must sign a blank check and guarantee payment before getting even the most critical services.[7]

[3] Michael Snyder, Medical Bills Responsible for Two-Thirds Of All Bankruptcies In The United States(April 17, 2019), https://www.econmatters.com/2019/02/medical-bills-caused-two-thirds-of-all.html .

[4] Himmelstein, David U., Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler. "Medical Bankruptcy: Still Common Despite the Affordable Care Act." (2019): 431-433.

[5] Reschovsky, James D., and Cynthia B. Saiontz-Martinez. "Malpractice claim fears and the costs of treating medicare patients: a new approach to estimating the costs of defensive medicine." *Health services research* 53, no. 3 (2018): 1498-1516.

[6] Lucia, Kevin, Jack Hoadley, and Ashley Williams. "Balance billing by health care providers: assessing consumer protections across states." *Issue Brief (Common Fund)* 16 (2017): 1-10; Lucia, Kevin, Jack Hoadley, and Ashley Williams. "Balance billing by health care providers: assessing consumer protections across states." *Issue Brief (Common Fund)* 16 (2017): 1-10; Cousart, Christina. "Answering the thousand-dollar debt question: an update on state legislative activity to address surprise balance billing." (2016).

[7] Healthcare Price Transparency: A State and Federal Approach, 2 (2013) (citing Regina Herzlinger, "Who Killed Health Care"?"

Providing a single payer system will level the playing field and eliminate both deferential treatment[8] and deferential pricing.[9]

A lot has been written about surprise bills,[10] indeed the US Congress just held a hearing on what was termed an epidemic in surprise billing,[11] but less is written about deferential treatment patients receive depending on their insurance status.

Today, I testify in support of a right to health care as defined in the New York Health Act. I'd like to describe my experience not just as a faculty researcher but as a patient.

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[8] For a discussion of deferential treatment s*ee, e.g.*, Hanmer, Janel, Xin Lu, Gary E. Rosenthal, and Peter Cram. "Insurance status and the transfer of hospitalized patients: an observational study." *Annals of internal medicine* 160, no. 2 (2014): 81. See also Rosen, Heather, Fady Saleh, Stuart Lipsitz, Selwyn O. Rogers, and Atul A. Gawande. "Downwardly mobile: the accidental cost of being uninsured." *Archives of Surgery* 144, no. 11 (2009): 1006-1011)("Uninsured Americans have a higher adjusted mortality rate after trauma. Treatment delay, different care (via receipt of fewer diagnostic tests), and decreased health literacy are possible mechanisms.").

[9] Concern about deferential billing, balance billing and surprise bills have reached such a pace that there is now a TV show dedicated to resolving health care billing called Show Me Your Bill: https://www.showusyourbills.com/ A summary of the shows investigative findings since 2015 can be found here: https://www.9news.com/article/news/investigations/medical-cost/youve-been-showing-us-your-bills-since-2015-heres-everything-thats-happened-since/73-609949669

[10] Garmon, Christopher, Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." Health Affairs. Vol 36. No. 1 https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970; Cooper, Zack, Fiona Scott Morton. 2016. "Out-of-network emergency-physician bills—an unwelcome surprise." N Engl J Med2016; 375:1915-1918. https://www.nejm.org/doi/full/10.1056/NEJMp1608571; Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." *USC-Brookings Schaeffer Initiative for Health Policy* (2019), https://www.brookings.edu/wp-content/uploads/2019/01/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf; Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. *Surprise! Out-of-network billing for emergency care in the United States*. No. w23623. National Bureau of Economic Research, 2017; Dossani, Rimal Hanif, Michael Brisman, and Luis Tumialan. "It is Time for Federal Protection Against Surprise Medical Billing." *Neurosurgery* 84, no. 1 (2018): E101-E102.

[11] Subcommittee on Health (Committee on Ways and Means), Hearing on Protecting Patients from Surprise Medical Bills (May 21, 2019), https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=109508

As a CUNY professor, I am a state employee insured under the city health insurance. As a professional, I have always been privileged to have health insurance.

In Fall 2016, I was heading to my doctor for my annual checkup. It was a rainy day. I slipped on a subway grate and fell. My arm snapped in two just above my wrist. It hurt. A lot. Two good Samaritan strangers saw my fall and helped me up. In downtown Manhattan, I handed my bag with my wallet, phone and laptop to two complete strangers who accompanied me to a hospital owned Urgent Care Center a few blocks away.

One of my rescuers told me she had broken a bone recently and was treated by the facility (and indeed the Center website reads, "We…manage broken bones.") The two women walked me to the Urgent Care Center. I showed the receptionist my visible broken arm and asked if the center could help me. The receptionist said they could and my good Samaritans helped me get my insurance cards out of my wallet.

The receptionist smiled and ran my insurance information. She then looked at me and told me that on further thought I would be better off going to a hospital ER. She said my arm was to severely broken to be treated by their facility. She said it did not make sense to be treated at the Urgent Care Facility and then sent to the ER anyway. She also told me it was a bad idea to order an ambulance. She recommended a cab as it would take less time than waiting for an ambulance and then having traffic prevent the ambulance from moving rapidly.

I had insurance at the time so, despite being a professor of health law, I did not recognize or suspect my treatment as a classic, almost textbook case of patient dumping.[12]

The receptionist helped me to the cab and I proceeded to the nearest ER. The ER receptionist again took my insurance information. When I was seen, the doctors set my arm using only their hands and then put my arm in a cast. The ER physicians told me I needed surgery but said they would not perform the needed surgery despite the fact that they were residents training in a well-respected orthopedic program specializing in wrist repair.

The doctors told me if I did not have surgery within two weeks I would likely lose functional use of my wrist. I was discharged with a prescription for a few days-worth of pain killers but no referral to a doctor or hospital or any information on how to have my wrist properly treated and repaired.

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[12] *See* Hsuan, Charleen, Jill R. Horwitz, Ninez A. Ponce, Renee Y. Hsia, and Jack Needleman. "Complying with the Emergency Medical Treatment and Labor Act (EMTALA): challenges and solutions." *Journal of Healthcare Risk Management* 37, no. 3 (2018): 31-41("The respondents stated that hospitals may be financially interested in avoiding Medicaid and uninsured patients because reimbursement rates are typically too low to cover the hospital's costs. One respondent predicted that hospitals, if left on their own, would "literally put in a credit card swipe on the front door."). *See also* Rosenbaum, Sara, Lara Cartwright-Smith, Joel Hirsh, and Philip S. Mehler. "Case studies at Denver Health: 'patient dumping' in the emergency department despite EMTALA, the law that banned it." *Health Affairs* 31, no. 8 (2012): 1749-1756; Cohen, Beverly. "Disentangling EMTALA from medical malpractice: revising EMTALA's screening standard to differentiate between ordinary negligence and discriminatory denials of care." *Tul. L. Rev.* 82 (2007): 645; Lee, Tiana Mayere. "An EMTALA primer: The impact of changes in the emergency medicine landscape on EMTALA compliance and enforcement." *Annals Health L.* 13 (2004): 145; GAFFNEY, ADAM, and HOWARD WAITZKIN. "Policy, Politics, and the intensive care Unit," https://examdev.theaba.org/E-Library/texts/2/3.pdf (impact of under-insurance on care in the ICU); *See generally* Zuabi, Nadia, Larry D. Weiss, and Mark I. Langdorf. "Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements." *Western Journal of Emergency Medicine* 17, no. 3 (2016): 245; Abel, Emily. "Patient Dumping in New York City, 1877–1917." *American journal of public health* 101, no. 5 (2011): 789-795; Blalock, Kaija, and Sidney M. Wolfe. *Questionable Hospitals: 527 Hospitals that Violated the Emergency Medical Treatment and Labor Act:A Detailed Look at" Patient Dumping*. Public Citizen Health Research Group, 2001; Enfield, Lisa M., and David P. Sklar. "Patient dumping in the hospital emergency department: renewed interest in an old problem." *Am. JL & Med.* 13 (1987): 561.

When I got back to my office I learned –to my shock-- why I had been refused treatment not once but twice—by two different facilities. My health insurance had been accidentally canceled by my employer.

I was being treated as an uninsured patient even though I did indeed have insurance. And neither facility that denied me full and proper treatment was upfront about the problem: my lack of insurance.

The law requires that a patient be stabilized in the ER,[13] but not that medical treatment be given to restore the level of use I had before the accident. Surgery to restore use was deemed elective surgery. And since I was perceived as an uninsured patient I was not given the option to have the treatment the physicians so emphatically stated I needed to have a usable hand.

When I returned to my office I began the process of trying to find a doctor and a hospital to perform the surgery. Doctor after doctor's office checked my insurance and refused to even book an appointment because I was showing –again erroneously—as an uninsured patient. Promises to pay cash or personally guarantee my bill (options most patients would not have) held no sway for most doctors. The doctor who did agree to see me told me he would accept cash payment and a personal guarantee for any further unexpected costs, but the hospital where he had privileges to perform surgery would not extend the same curtesy. If I could not show insurance, I could not have the surgery.

[13] Emergency Medical Treatment & Labor Act (EMTALA), 42 U.S.C. 1395dd

Paying out of pocket was not an option. No insurance. No surgery. No use of my wrist.

My story has a reasonable happy ending. My employer worked very, very diligently with me to get my insurance restored just within the two-week window so I could have the surgery I needed.

But I was lucky. I was perceived as being an uninsured patient when in fact I did indeed have insurance. I had the time, the knowledge and the resources to get my health insurance restored.

A patient without insurance (or a patient with a less flexible job than mine) may not have had the same result.

I tell this story for two reasons. First, there is an assumption that insurance or lack thereof is a problem of payment when in fact insurance status itself is very significant in determining treatment available to patients. Second, there is an assumption that having insurance will ensure that patients get the care they need when they need it; but all ensured patients run the same risk I faced if they should arrive in an ER without documentation of their insurance.

My perceived lack of insurance was due to an error by my employer. But the same result could just as easily occur if an uninsured patient arrives at an ER unconscious and separated from ID (for example if a bike or car accident occurred and a wallet or purse was lost or stolen on the way to the hospital).

The bottom line is the current system we have is not just expensive and wasteful;[14] the current system is dangerous for patients. Every person who enters the hospital should be entitled to proper treatment. Not just stabilization.[15] Nobody should be denied treatment that could restore function of a limb because the hospital and provider fear the patient may not pay the billed amount.[16]

Healthcare is already rationed in this country,[17] creating a one payer system and a right to health care will level the playing field to ensure both that patients get the treatment they need,[18] and that patients don't get onerous bills that drive the patient and/or their family into financial debt or bankruptcy.

Thank you very much for your time and consideration. I'm happy to take questions. I can be reached by email at Elizabeth.geltman@sph.cuny.edu and by telephone at 202-320-4520.

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[14] *See,* Anderson, Gerard F., Peter Hussey, and Varduhi Petrosyan. "It's Still the Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt." *Health Affairs* 38, no. 1 (2019): 87-95; Gale, Arthur. "It's the Prices, Stupid: Why the United States is So Different from Other Countries." *Missouri Medicine* 116, no. 1 (2019): 6; Rosenthal, Elisabeth. "An American Sickness: How Health Care Became Big Business and How You Can Take It Back." *Missouri Medicine* 115, no. 2 (2018): 128.

[15] Emergency Medical Treatment & Labor Act (EMTALA), 42 U.S.C. 1395dd

[16] *See, e.g.,* Macdonald, Theodore, and Richard Mayon-White. *The global human right to health: Dream or possibility?*. CRC Press, 2018.

[17] Hoffman, Beatrix. "Health Care for Some: Rights and Rationing in the United States Since 1930." (2016); Mullally, Sasha. "Health Care for Some: Rights and Rationing in the United States since 1930 by Beatrix Hoffman." (2016): 243-246. *See also* Meyer, Michael. "The Ethics of Universal Health Care In The United States." (2016).

[18] Gaffney, Adam, Steffie Woolhandler, Marcia Angell, and David U. Himmelstein. "Moving forward from the Affordable Care Act to a single-payer system." (2016): 987-988; Brown, Theodore M. "Brown responds: Why Hillary Clinton is wrong and Bernie Sanders is right." (2016): 1362-1364; Gaffney, Adam. "Health Insurance Reform in the United States—What, How, and Why?." *Journal of Policy Analysis and Management* 37, no. 1 (2018): 188-195; Friedman, Gerald, and Gordon Hall. "Yes, We Can Have Improved Medicare for All." (2018).