CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON FINANCE JOINTLY WITH THE
COMMITTEE ON CIVIL SERVICE AND LABOR

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HELD AT: Committee Room - City Hall

B E F O R E: JULISSA FERRERAS-COPELAND
Chairperson

I. DANEEK MILLER
Chairperson

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

Bob Linn, Commissioner
Office of Labor Relations

Claire Levitt, Deputy Commissioner
Healthcare Costs Management

Ken Godiner, Deputy Director
Office of Management and Budget

George Sweeting, Deputy Director
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Marty Davis, Labor Economist
New York City Independent Budget Office, IBO

Maria Doulis, Vice President
Citizens Budget Commission

[sound check, pause]

[pause]

CHAIRPERSON FERRERAS-COPELAND: Good morning and welcome to today's oversight hearing on the Health Care Savings Plan under the City's Collective Bargaining Agreements. I am Julissa Ferreras-Copeland. I am the Chair of the Finance Committee. This hearing is being held jointly with the Committee on Civil Service and Labor Chaired by Council Member Daneek Miller. I want to thank everyone for joining us today. We've been joined by Council Members Levine, Matteo and Crowley. Today the Committee will hear from the Administration on the progress of the Health Care Savings Plan put forth by the Administration and Municipal Labor Committee, an umbrella organization representing all of the City's union. The Savings Plan agreed to by the parties in May 2014, created a process to achieve $3.4 billion savings on insurance costs over a four-year plan. By way of--by way of a brief background, since Mayor de Blasio took office and his--and his Office of Labor Relations have negotiated contracts with unions representing 95% of the city's workforce following a pattern that was projected to cost the

City $14 billon over the four-year financial plan. To partially offset this cost, the Administration and the MOC entered into an agreement to achieve savings on healthcare costs, which stated that $400 million must be saved in Fiscal 2015; $700 million in Fiscal 16; and $1 billion in Fiscal 17; and $1.3 billion in Fiscal 18. Last April, the committee held a hearing on the savings plan because there was a considerable lack of detail known about the plan. At the time before the hearing, formal details of the plan and its progress were limited to the two-page agreement of the MLC, the three-page Administrative Update from the Office of Labor Relations to the Mayor's Office in December 2014, and the opinions published by the Administration and the press. This year, which stage we have to do all over again. (sic) On Monday of this week, the Administration and the MOC agreed to a number of changes to the City's Health Plan, and agreed to use the $58 million for the Health Insurance Premium Stabilization Fund to fill the gap where the Saving Plan feel short of meeting its target. This announcement that the savings target would not, in fact, be met by the program's initiatives implemented by the savings was made this

morning for the first time. In all of the reports previously issued by the Administration and in conversations with the Council, we have been misled to believe that the savings from the plan itself would be enough to reach the goal. I'm extremely disappointed and frustrated at the Administration's unwillingness to collaborate with the Council in preparation for this hearing by refusing to provide us with yesterday's 11-page memorandum or any other information about this agreement, and instead forcing the Council to read about it in the news this morning. It is completely unacceptable that the Administration would not provide information to-- would provide information to the press and not to the Council. Council staff has been preparing for this hearing for over a month, and has attempted to engage with the Administration multiple times. This week specifically to learn more details about your new agreement. However, the Administration rebuffed these efforts, and instead chose to disclose information to the press instead of their government partners. The Council hearings serve as an important tool for public to be informed and engaged in their government and the decisions that affect them. It is

incumbent upon us as government officials to work together to have productive and informative hearings. So I expect that in the future you will be more willing to engage in a free flow of information for everyone's benefit. In yesterday's memorandum the Administration and the MLC say that the savings will partially be achieved by providing economic incentives to rely more on primary care, offering a new HIP HMO preferred plan, continuing the dependent eligibility verification audit, and introducing a telemedicine and online appointment scheduling platform. While this certainly is commendable, the committees look forward to hearing testimony regarding how these programs translate into actual savings for the City. The Council's understanding is that the vast majority of the City's healthcare costs consist of the premiums paid to Emblem Health, the insurance company that ensures approximately 90% of the City's workforce through GHI or the HIP HMO. The premium rate is approved by the New York State Department of Finance Services, but it is unclear how the program and the savings plan led to a lower premium rate, and a lower overall cost to the City. In addition, in 1983, the City and the MLC agreed

that the City's costs of healthcare insurance would be the HS--the HIP premium rate with employees bearing any costs exceeding the HIP premium rate. At this time, the HIP rate was lower than the GHI rate. So to prevent those with GHI from having to pay the difference from their paycheck, the City started making payments into the jointly controlled Health Insurance Premium Stabilization Fund representing the difference between the HIP rate and the GHI rate. Now, however, the GHI rate is lower, and the GHI Plan is more popular, which means the City is making large unnecessary contribution. As I mentioned the Administration and the MOC agreed to use $58 million from the fund to make up the difference between the savings that the plan was actually able to achieve for Fiscal 2016 and the target savings amount. First, it is unclear to this committee how spending City dollars to fill a gap could accurately be described as a savings. And second, why is the transfer from the fund necessary if it is true. As the Administration reported as recently as December 15 that the City was on track to meet the savings for Fiscal 2016. The Council looks forward to hearing testimony regarding the long-term plans for this

fund, whether it will be used again the future years to account for the failure of the savings plan to meet its target, and whether the City anticipates the need to make sure large contributions going forward. Before we hear from the Administration, I will now turn the mic over to the Chair of the Committee on Civil Service and Labor, Council Member Miller to make a statement.

[background noise, pause]

CHAIRPERSON MILLER: Thank you, Madam Chair. I, too, acknowledge Council Member Van Bramer, and Council Member Gibson who have just joined us. Good morning. My name is Council Member I. Daneek Miller, and I am the Chair of the Committee on Civil Service and Labor. I'd like to thank Chair Ferreras-Copeland for holding this very important follow-up hearing while the Finance Committee is already extremely busy with the Preliminary Budget. The staff of the Finance Committee has done a tremendous job in preparing this today considering the lack of information available to them. I continue to be concerned about the agreements between the City and the Employee Union, and the Administration to save $3.4 billion in healthcare

costs during the four years of the Collective Bargaining Agreements term. Of course, most are entering--we--we are entering year two. We've been given some numbers that indicate the plain is on track for the first year, and now we see what the second year is providing. We've been given more details about the program, but I still have some questions of which in particular I want to focus on just the savings to the city, not just the savings to the city, but the savings to the municipal workers who are receiving these benefits. I want to know how much, if at all, these measures are helping the workers--helping the workers. In--in addition, I have questions about HIP HMO, the plan rate. The City's contributions to municipal employees' healthcare costs is based upon the City's Local Law. Over the decades--over the decades, the City has been subsidizing workers' healthcare. The baseline plan has changed many times. However, it has been the HIP HMO rate for 19 years now. Considering HIP not--HIP ceased to exist as a separate entity several years ago upon its merger with GHI, it is an open question to me whether this particular plan is an appropriate benchmark for determining the City's contribution to

the City's healthcare insurance benefits. I'm looking forward to hearing from the Administration, and I'm also looking forward to hearing from other experts in this area including the unions and other parties involved in this agreement. So with that, I'd like to thank Matt Connor and Mr. Zoloff (sp?) for their work on this hearing today and, of course, I'd like to thank Ali Rasoulinejad for his work. And I'm looking forward to having the Administration and others answer some very critical questions about healthcare, and how is--how services get delivered and its savings. Thank you.

CHAIRPERSON FERRERAS-COPELAND: Thank you and we've been joined by Council Member Rodriguez. You may begin after my counsel swears you in.

LEGAL COUNSEL: Do you affirm that your testimony will be truthful to the best of your knowledge, information and belief?

COMMISSIONER LINN: Yes, I do.

CHAIRPERSON FERRERAS-COPELAND: You may begin.

COMMISSIONER LINN: So good morning, Chair Ferreras-Copeland, Chair Miller, Council Members of the Civil Service and Labor Committee and

Finance Committee. Thank you for the opportunity to testify today. Before I make a couple of opening comments in response to some of the comments that the Chair made, I'd like to just say that I'm--I'm joined on my right, your left, by Claire Levitt, the Deputy Commissioner for Healthcare Costs Management, and Ken Gardner, Deputy Director of the Office of Management and Budget.

CHAIRPERSON FERRERAS-COPELAND: [off mic]

COMMISSIONER LINN: Yes, Claire Levitt, Ken Godiner. Hi, I might begin before my prepared remarks by saying how surprised I am by your initial comments. I believe that the City has spent 26 months reaching one collective bargaining agreement after another, and now making settlements with 95% of its workers in a fiscally responsible fashion in way that was fair to the workforce, fair to the taxpayer, fair to union leaders. Contracts have been ratified overwhelmingly by each of the con--each of the unions, and as part of that, we negotiated a health [beep, pause, mic cut out] Is it? No. [background comments and laughter]

CHAIRPERSON FERRERAS-COPELAND: Oh, it's unfortunate. Ours are working. I guess I have the

mic. How about you sit next to me? No. Let's see if we can swing this. Can we bring that mic over there or is it the box.

MALE SPEAKER: Oh, yeah, here's one over here.

CHAIRPERSON FERRERAS-COPELAND: [interposing] Or that mic over there? Okay, so let's bring that one over. [background noise, pause] All right.

COMMISSIONER LINN: All right, how is that? So as I was--as I was saying, and I'm not sure when the mic cut out--I believe this Administration has responsibly negotiated with all of its workers. Ninety-five percent of its workers had reached collective bargaining agreements that were responsible, fair to the workers, fair to the taxpaying public, ratified by overwhelming majorities and generally viewed by those fiscal experts looking at the city as totally responsible and reasonable. And, in fact, brought settlements in at a time when the city had been for--without settlements for years making it impossible to accurately analyze the city's budget situation, and all that has now been resolved. As part of those labor settlements, we reached a

historic healthcare plan--savings agreement, where it was it was understood that the parties together through collective bargaining, labor and management working collaboratively would join to find savings in a health plan to make changes that had not been made in 30 years.

CHAIRPERSON FERRERAS-COPELAND: Commissioner Linn, I don't want to be disrespectful because I do want you to start your testimony, but I also want to be clear. I wasn't questioning whether--whether you did a great job or not, right, because that's what this hearing is about. What I am concerned is that I find out about a report that normally and should have been shared with this committee is released to the press before--before then you do to our committee. We have always had a collaborative relationship and, therefore, if we're preparing for this committee, that report was essential for us to prepare for this. That is what I'm questioning. What's in the report is what this hearing is for.

COMMISSIONER LINN: [interposing] So, let me--

CHAIRPERSON FERRERAS-COPELAND: So, I want to be clear on that.

COMMISSIONER LINN: And let me be clear that--clear on this. In a collective bargaining process one can't and shouldn't release publicly the facts and circumstances around agreements before they're--before they're completed. Our settlement with the MOC was made Monday of this--of this week. So it was made four days ago. We reached settlement.

CHAIRPERSON FERRERAS-COPELAND: And we could have gotten it four days ago.

COMMISSIONER LINN: The set--

CHAIRPERSON FERRERAS-COPELAND: [interposing] Okay, I--I'm not going to go back and forth. We're going to have a Q&A--

COMMISSIONER LINN: [interposing] Okay.,

CHAIRPERSON FERRERAS-COPELAND: --after testimony.

COMMISSIONER LINN: Okay, but--but the point is we reached a settlement with our unions, wit the Municipal Labor Committee four days ago. We then put that into our Quarterly Report because we thought it made no sense to bringing a quarterly report that didn't have the very important changes we had just

negotiated, and our quarterly report was done yesterday, and that was--that was made public last night, and on our--and put on our website, and I think produced to your--to the--to the members of this committee last night. But I apologize--

CHAIRPERSON FERRERAS-COPELAND: [interposing] It was produced to us in the press this morning. It was not produced to us last night. So let's be clear, but--

COMMISSIONER LINN: [interposing] Then I misunderstood.

CHAIRPERSON FERRERAS-COPELAND: But you don't--you don't get to ask me the questions. I'll ask you the questions. I can't wait to hear your testimony so that you can show me all your savings. Commissioner Linn, I would love for you to start your testimony.

COMMISSIONER LINN: I would be happy to start with my testimony. Over the past year the City's and the Municipal Labor Committee have worked together to tackle the difficult challenge of identifying significant healthcare savings and also improving healthcare outcomes. So today we're excited to report on the success of the Municipal

Labor Committee and the City to its meeting these goals, not just for 2016, but we're also going to demonstrate how we're meeting our goals for 2017, over a year early. We'll detail not only how the $700 million targeted savings will be secured for 2016, but also how the billion dollars required for Fiscal 17 is already projected to be secured as an important, as a result of the important changes, and I believe unprecedented changes to the City's health plan. As you recall, when Mayor de Blasio took office in January 2014, every single contract with the municipal workers had expired. As of today, we've reached agreements with 95% of the workforce, both civilian an uniformed. As part of that agreement, we secured a commitment to have labor and management work together to generate cumulative savings of at least $3.4 billion over the four fiscal years, 2015 through 2018. By agreement, the plan did not specify how the healthcare savings would be accomplished, only that it would be done collab-- through--by collaborative effort between the City and the Municipal Labor Committee aimed at bending the healthcare cost curve. By agreement, the first--in the first year, a billion dollars was paid from the

Stabilization Fund to the City, and I'll pause for a second to talk about the Stabilization Fund. You are correct that it was created in the early '80s. As a matter of fact, I was General Counsel of Office of Labor Relations in the early '80s and then became Director of the Office of Labor Relations in '83. And that, in fact, as you accurately stated, the Stabilization Fund was intended to use the HIP HMO rate as the benchmark for paid--for contributions, and it was thought that the GHI Plan, a fee for service plan would cost most more than the--HIP plan. And, therefore, dollars were put aside in collective bargaining to augment the GHI payments so that the city workers would have a cushion, the Stabilization Fund to protect city workers from having to pay substantial amounts for healthcare, and that was the--the purpose of the plan. All during the '80s when I was here in my last--and the last time I served as Director of the Office of Municipal Labor Relations at that time, the HIP rates and the GHI rates were very close and, in fact, the Stabilization Fund did not generate very substantial savings at all, and--and it remained at a fairly low level during that period. In the 24 years when I was gone, that

agreement was never modified. So an agreement from 1982 and '83 was left untouched by three administrations 24 years of collective bargaining. And so, when we returned, when I returned in 2014, we faced and inherited the same labor agreement providing health that had been in place for 30 years, and pursuant to that labor agreement the city pays into a Stabilization Fund. As you accurately stated, the difference in cost is--it's what's called an equalization payment--the difference in cost of the HIP rate in comparison to the GHI rate. That is through collective bargaining. Employers cannot unilaterally change items in collective bargaining. They must negotiate it. And so what we did in this current--in this current labor agreement was we agreed that the City and the Unions would work together to find savings, that the Stabilization Fund could be used to help support the City budget. And I don't know if the screen shows--as you see on that screen $1 billion with a B was taken from the Stabilization Fund as part of the 2014 Labor Agreement and was--and the City was able to use that to support its collective bargaining agreement. So, in fact, for the first time a substantial number of

dollars were agreed to by the parties to come from the Stabilization Fund and be returned to the city.

Second, we agreed in the 2014 agreement that we would over the next four years save $3.4 billion. We would make $3.4 billion in healthcare savings. At least $400 million in 2015. As the chart shows, $700 million in 2016, a billion in 2017 and a billion point three--$1.3 billion in 2018. And we also reached another I think extraordinarily important agreement with the unions. We agreed that it we reached savings above $3.4 billion, the first $365 million in excess is savings. It will go back to the workforce as a bonus payment. As a much--as 1% bonus so the entire workforce could be paid, and if there are additional savings beyond that $365 million, it would be split 50/50. So this gain sharing agreement aligned labor and management's interests to work together and fundamentally change the labor management dynamic around common objective--the common objective of identifying healthcare savings. And, I think it is often lost of how important that change was because for 24 years, labor and management were yelling at each other that they wanted to change health benefits. And now we had an

agreement labor and management would work collaboratively to find changes in order to approve and make the system more effective, more efficient, and provide better care for workers. And so, as a result we've been able to work together to achieve remarkable changes, a win for the city, a win for the municipal unions for our employees, and the New York City taxpayers. The changes we agreed to will not only secure the promised health savings, but will also promote--and I can't overemphasize this--while we are reaching these savings, unprecedented savings, we're going to promote better utilization of healthcare resources and improve healthcare outcomes for City employees. For the first time, we've been able to use the City's claims data to drive decisions. I'm going to make that point again. Healthcare funds, healthcare programs throughout the country have always shared data, almost invariably. That is what they've been doing in the--since the end of the last century into the 1990s in 2000, they would share data, and have an analysis of data drive their decisions of how to improve their plan. That did not go on in New York City, and as a result of this agreement, we worked closely with the Municipal

Labor Committee to redesign our health plan--health plans to implement important modifications that provide incentives to obtain the most cost-effective and efficient healthcare. Details of the specific program savings for FY16 and 17 are provided in Exhibit A of my testimony, and will be discussed as we go through the presentation. And I do want to say--I want to take a moment to recognize the extraordinary efforts of the Municipal Labor Committee and their leadership under Harry Nespoli, President of the Sanitation Workers Union, and Chairman of the Municipal Labor Committee along with Arthur Pepper of the UFT, and Willie Chang of DC37, the Co-chairs of the Labor Management Health Insurance Policy Committee. Their leadership and willingness to work with us to achieve healthcare savings has helped transform vision into reality. We are now well on our way to meeting the $3.4 billion health cost savings goal, and we're optimistic we may achieve in excess of those. So we can generate the saving surplus in order to pay an additional bonus to the employees.

So let me start with data analysis. That one of the most significant deficiencies in the

City's ability to contain healthcare costs in the past 20 years was the failure to obtain and analyze claims data, to understand the nature of the overall healthcare utilization expense. We have now--we now jointly review that data. Key findings from the initial analysis gave us a clear picture of the trends and expenses that we need to address and proved extremely helpful in informing the direction of our program development by permitting us to focus more precisely on the specific problems we identified. The analysis compared data for the City's largest plan, Emblem Health, GHI and part of Blue Cross Health Plan known and CBP, which covers about three-quarters of the City employees and to benchmark. With our plan, the benchmarks as our--in comparison to our plan with the city employees with well managed plans and loosely managed plans. That's why we put up that graph now. Well managed benchmarks represent the best in the industry. Loosely managed benchmarks are representative of plans of convential--conventional utilization review, preauthorization and case management practices. These benchmarks were calibrated by actuary--an actuary to reflect the demographic profile,

geographic and profile and benefit--benefit design of New York City employee population. What emerged from the data's--data was analysis. It showed a picture of healthcare utilization that could be improved. So if you look at the Table 2 that I'm showing you, it made the point that while the healthcare total costs were not necessarily way out of the average, though were higher than well managed plans. If you looked at specific areas of our plan, there were specific areas where it said--the data said the parties need to look at these issues. Now, if you looked at emergency room visits, which is the second set of lines on our--on the graph I have here. Emergency room visits were 74% higher than you find in well managed plans. Urgent care visits were 106% more than you find in well managed plans. While at the same time, preventive care services, visiting your primary care physician for preventive care we are 144% below a well managed plan. Non-preventive, specialists care, office visits were well above what you'd expect to find in a well managed care. And general visits of radiology and special procedures were also way above what you'd find in a well managed plan. So what you're going to see is the use of this

data then drove, then specifically drove the types of decisions that labor and management made together to modify our plans. [pause] So as I said, that we had very high utilization in the emergency room, and this suggested that employees are using emergency room care when it could be better provided by their own physicians. Urgent care visits were exceptionally high, and this information combined with the emergency room visits suggest an increase in urgency are visits diminished primary care utilization rather than emergency room use. Outpatient preventive service for procedures like colonoscopies and mammograms are far below the utilization of well managed and loosely managed benchmarks. Physician specialty care utilization is well above the benchmarks. Radiology and pathology procedures performed in physician offices have extremely high utilizations compared with the benchmarks. In particular, the over-utilization of emergency rooms and urgent care and under-utilization of preventive services not only have significant cost implications for the plan, but indicate that our employees are not making the best use of their benefit plans to protect their own health and the health of their families.

So as a result of this analysis, the Municipal Labor Committee and the City worked together to redesign the health plan with changes that were developed to help encourage more appropriate utilization of healthcare. Strong primary care is recognized as essential to include healthcare outcomes and lower costs. So new benefit design developments were incorporated into the plan to encourage employees to utilize the best site for care for their specific health situation. To help address the underutilization of primary care and the overutilization of specialty care, the co-pay for physician service--for physician specialty care visit, which used to be $20 since 2004 is now being raised to $30 while primary care co-pay remains at the low $15 per visit. Mental health visits also remain at the co-pay of $15 to ensure employees have continued access to obtaining necessary mental healthcare. For comparison purposes, it's interesting to note that the 2015 Kaiser Employees' Health Survey, probably the most important survey in this country that looks at healthcare costs around the country showed that the average employee pays $24 for primary care physician co-pays and $37 for

specialists. So we still are low, but it--we adopt a similar differential between primary care and specialists visits that are important to incentivize workers to start with the primary care physician. To help address the high cost of overutilization of emergency rooms, most of which is for care that can more effectively be delivered elsewhere. The current co-payment of $50 per employee is being raised to $150 a visit. If the patient is admitted to the hospital for the emergency, the co-pay is waived. To encourage employees to utilize pre--important preventive services, all preventive care visits and procedures will have a zero dollar co-pay. This will include services for depression screening, mammograms, well women visits, contraceptives, breast feed--and breast feeding supplies. By agreement between the City and the Municipal Labor Committee, the additional cost for these items will be borne by the Stabilization Fund rather than the City's Health Plan. And let me make that point again. Dollars from the Stabilization Fund cannot be taken unilaterally by the employer. It requires the joint agreement of labor and management. So what we achieved here was the agreement of the unions to use

these dollars to improve primary care visits and to improve wellness type efforts and, therefore, it is a labor management agreement that we reached on Monday that lets us make these types of improvement. To provide even better access to low-cost convenient primary care, we're entering an agreement with Emblem Health, our current insurer, to provide access to all of physicians at their 36 Advantage Care Physicians, ACP's locations around the city, and in those Advantage Care Physician locations, there will be zero co-pay. But that doesn't have a cost to the City because Emblem is providing a guarantee that the additional costs of zero co-pay will be more than offset by the savings from the improved coordinated care at their locations. So we are providing more effective care to our workers at no additional costs to the taxpayer. And a list of locations are included in the Exhibit 7. (sic)

To help encourage the use of primary care while providing access to urgent care, the new co-pay for urgent care was established as a higher point to the co-pay for physician care, but lower than the emergency room visit. And for high cost radiology procedures like MRIs, CAT scans, the co-pay is being

increased to $50. For diagnostic laboratory testing, co-pays are being increased from $15 to $20, and you see that in Table 3, and the most significant point that I would like to bring to your attention is the savings from these changes, the very real dollar savings that--that those that said what types of changes are we making specifically in the plan, these are changes we just reached--reached on Monday with the Municipal Labor Committee. These plans will save almost $85 million per year, which will grow with--which can grow with--with trend. So--but at least $85 million a year is now being saved by these changes. To help support these changes, we're offering two important new programs to provide employees the new tools to help locate appropriate care and reduce emergency utilization: Telemedicine, which were access to physician services will be offered online by 24 hours--24 hours a day. And this service will expand City employee's access to immediate physician availability and help reduce the cost and inconvenience on necessary emergency room utilization. And ZocDoc Online Scheduling, a New York City versions of the ZocDoc website will enable employees to go onto the site and select available

physician appointment times online, and the site will direct employees to physicians in their network and will indicate those ACP physicians where the co-pay is zero.

So let me say neither of these items are part of our savings. The $85 million comes from the changes in co-pays. What these two changes do is it helps employees choose effectively, find their primary care physician, find doctors where there's a zero co-pay, and so we've added this assistance to the workers so they can use these processes as efficiently and effectively as possible. We recognize that these are consequential changes for the City employees and, therefore, an important aspect of implementing these changes would be educating employees on how to use the new plan efficiently. In conjunction with the Municipal Labor Committee we'll be devoting an intensive period between now and July 1, and let me make that point. We are starting these provisions in July 1 as opposed to earlier so that we can sufficiently educate employees about them. Had we introduced them earlier, then the savings would have occurred earlier. But we thought together with the Municipal

Labor Committee it was important to hold these changes until July 1st so employees would have an opportunity to understand them, have the opportunities to figure out where to find the physicians and that, therefore, the savings that we're--that are incurred by delaying these-- Things that were lost by delaying these--these changes, we used savings from--we used additional dollars from the Stabilization Fund to make up for the $700 million, but our thought was--the critical issue was to make sure that we are meeting the billion dollars for Fiscal 17 in a fair and reasonable way, and that we're able to identify those savings a half year before the--the year was to begin, four months before it was about to begin.

So in addition to the changes in GHI, we also made design changes to the HIP HMO Plan, and while that 75% of the City employees are in the CBP Plan, another 20% are in the HIP HMO Plan, and another extraordinarily important we're making as of July 1 is the introduction of a new more cost-effective HIP HMO plan. This new program is called the HIP HMO Preferred Plan, and it also provides an innovative approach to achieving better healthcare

outcomes. The plan provides the same coverage as the current HIP HMO plan except that the plan encourages the use of preferred providers. The HIP HMO Preferred Providers are working under what's known as value based arrangements, which provide incentives to physicians to provide improved and better care coordination. These measures can include re-admission avoid--avoidance, immunizations, screening programs, controlling high blood pressure, controlling diabetes, A1C rates, depression screening, tobacco use and prevention, and other measures to assure better health outcomes. The co-pay for using preferred providers remains zero. However, there's now a $10 co-pay for care when a patient goes to a non-preferred provider. The rup-- disruption will be minimized by the fact that currently 60% of City employees in the HIP HMO are already using HIP preferred providers. The new program offers not only lower overall cost to the City for employees enrolled in HIP HMO program, but as it lowers the benchmark that we've discussed before, the rate that drives payment for all employees and that this program lowers the benchmark rate while providing better care for employees, and

the total savings from the program, the total annual savings from this program is $64 million. So together these two--and I'm just going to get to that in a moment--will save $150 million per year. There are a number of other changes we contributed to the cost savings success including care management program extension--expansion. The City and the MLC together selected Empire Blue Cross the Care Management programs effective January 1, '16. We believe that the change in vendor will maximize the savings for the city and provide an intensive level of management support for employees, the case management support for employees. At the same time, we implemented new pre-authorization requirements for outpatient procedures consisted with what nearly every employer insurance program has been doing for decades. And we only were able to achieve that through the joint collaborative efforts with our workers. This expands further on the New Care Management Programs implemented in April '15, and should help increase savings by providing case managers to assist our sickest employees and their family members in navigating the healthcare system to obtain the highest quality and most cost-effective

care. We've also with the union implemented a diabetes case management program. Diabetes is a growing epidemic in the United States. Nearly 30 million Americans have Diabetes. Patients diagnosed with Diabetes can prevent serious complications by carefully managing their disease. To help support our employees who are diabetic, beginning July 15--1/15--so let me make that point. It just began. For years, the City did not have diabetic case management programs. We now have it in effect. And so I'm pleased that Diabetes or Gestational Diabetes has been offered one-on-one case management services with a registered nurse to help them manage their condition. Several hundred employees have already enrolled in the program, and we're providing outreach to more and more employees. We're continuing the Dependent Eligibility Audit. The Comprehensive DEVA audit saved over $100 million so far, and will be continued on a limited basis for three additional years to assure that enrolled dependents are indeed eligible. Changes to the Health--Emblem Health provider schedule, Emblem introduced reduced payments to their providers for radiology and dur-durable medical equipment in 2016. So as a result--I wanted

to put up that table--you can see that the combination of these two plans will be to save--these two programs I talked about the HIP Program and the GHI CBP Plan Savings saves $149 million per year. You add that to the $851 million that have already been identified, we are now showing projected savings for Fiscal 17, the year starting July 1, '16, we are showing the billion dollars that we have--the Union and management agreed in the May 14th Agreement on Health Care. So are four months early announcing that we have in place a plan to save the billion dollars for Fiscal 17, and we now can work together with the Union to possibly save more than a billion dollars in '17, to make sure that we are on target to meet--meet the Fiscal 18 savings, and hopefully we can also find dollars so that we can wind up paying the employees the lump sum payment that was part of the Gain Sharing Program that we discussed. And if you take a look at the--the numbers of the table that is now being shown, you can see that we indeed met our target for 2015. We have the $700 million of 7--in 17, and we are showing over a billion dollars in '17. I'm sorry--$700 million for '16, over a billion dollars in '17 and we now will work together to close

the $232 million need for '18, and hopefully we'll be able to go above those numbers and have savings in excess of the $3.4 billion. And finally as part of the overall deal, we agreed that an additional $121 million would come out of the Stabilization Fund, which again would be split evenly. The City would be getting $60 million and the Welfare Funds would receive a one-time $100 per employee payment to their Welfare Funds as part of the overall settlement.

So beyond these items and the saving element--savings elements I've described, we have also continued our focus on improving the health of New York City employees. We're exploring a number of wellness initiatives. The data we obtained also helped us to identify the chronic conditions that can help employees address--that we can help employees address. The data analysis demonstrates that city healthcare expenses for heart disease, diabetes, hypertension, some cancers and other chronic diseases represents over 50% of the City's total healthcare spend suggesting the programs to help address lifestyle factors that contribute to these diseases, could impact costs as well as improve overall health of New York City employees. To that end, we've been

working on a number of different approaches to health and wellness, but let me before I go on make the point it was joint analysis of data with the unions that helped identify what were the wellness efforts, where were the areas that we should be looking. An across-agency team led Ola Laura (sic) has been working at advancing an improved and sustainable culture of health that will support our workforce getting healthier and staying healthier. A number of programs have been introduced, and more will be implemented shortly to address fitness, nutrition, obesity, smoking cessation and stress reduction for the City's workforce. Since so many of our employees stay with us for many years, and continue their coverage with the City and the City as retirees, our investment in their health is not only the right thing to do, but can also have important future savings implications. While some of these approaches won't quantifiable savings, and I want to point out none of these approaches are a part of the savings we've identified so far. But while these savings can have--won't have quantifiable savings, we can specifically measure in the next year or two, to contribute toward the health savings target, they are

important long-term strategy to improve the health of the employee population and, thereby, reduce long-term healthcare costs. [background noise] Fundamental to are programs are a belief that making wellness programs available on the worksite will mean they have an even greater chance of impacting people's lives. The convenience of work site programs makes it possible for employees to fit them into their busy schedules. We've already had initial success implementing the CDC's Diabetes Prevention Program at several agency locations. The CDC estimates that nearly 30% of the population is pre-diabetic, and many of them will become diabetic. The CDC's prove--proven curriculum can prevent a large number of people from becoming diabetic. While many diabetic prevention programs have limited success engaging people in the community base programs, we hope that by offering the convenience of work site programs, we can interest many of our employees. We plan to bring the program to a number of new locations this year. We also recognize that obesity impacts more than a third of the population, and obesity related medical conditions including heart disease, stroke, diabetes and some forms of cancer

they're the leading causes of preventable death. To help address this, we'll be offering New York City employees access to a nationally recognized weight management program at minimal cost in the work place, in their communities and online. And by agreement with the Municipal Labor Committee, this is a joint labor management initiative where half of the employee's cost of the program will be subsidized by funding from the Stabilization Fund. So there it is again. We are using Stabilization Fund dollars in this area to promote workplace wellness weight management programs. We specifically reduce the rate offered for weight management program, and employees' monthly cost to participate will be very low. We'll begin offering this program in the spring.

The Culture of Health team is also working on rolling out several agency based work site wellness demonstration projects in 2016. The programs will focus on providing health risk assessments and personal coaching to help identify and encourage employees who may want to participate in smoking cessation, stress management, nutrition and fitness programs to improve their health. We hope to use the demonstration project experience to

validate the effective impact of wellness programming and healthcare (sic) and health costs, employee engagement and reduce absenteeism so we can support scaling this program citywide. We continue to promote the free flu shot program as an important preventive step to reduce more costly emergency room and doctor visits. The program, which began for employees in 2014 was offered again in 2015 through--to--in September '15 through December of 15. This year, it was expanded to include covered dependents and pre-Medicare retirees. Flu are offered at no cost to employees a participating worksite locations as well as at physician offices, and participating pharmacies throughout the City. To help support these programs OLR has introduced a new section website--on its website, Employee Wellness that contains valuable information, links and tools to help maximize access to appropriate healthcare and educate the workforce about health issues in the City's Health and Wellbeing Programs.

Future plans for Fiscal 17 and 18. We believe, as I've said, we've already secured the 2016 and '17 savings goals. We also are actively working in partnership with the Municipal Labor Committee to

explore new programs to enhance cost savings. We're continuing to look at expanding innovative healthcare delivery models that emphasize primary care focus. These models can provide access to the highest quality care, and the best service of our workforce especially those most at risk. With these models, the providers of care may assume some of the financial risks of the patient outcomes. We'll be exploring self-insuring the plans to further reduce risk change--changes and taxes is a--it's a viable option, and typically plans for far smaller than New York City utilize self-funding as the least expensive option. For our retiree population, we're also looking at expanding Medicare Advantage Program options, which can potentially provide even coverage to report--to retirees while capping the costs for the city. So let me conclude at this point. We are extremely pleased to be reporting today that we've been able choose--achieve success for the first two years of the Health Care Cost Savings Program, and even more importantly, that we will reach the billion dollar saving for 2017 based on the programs that we've just concluded. We are especially proud that this has happened in a collaborative atmosphere

between the City and its unions. Looking to Fiscal 17 and 18, we're committee to continue our work with the Municipal Labor Committee to identify the right programs for improved patient outcomes, to improve the health of the workforce, and to meet our cost savings goals. We are enthusiastic about potentially being able to share the health cost savings with the workforce in the future. To keep all stakeholder-- holders informed, we intend to continue to issue our quarterly updates as we move forward, and we'd be happy to come back to the Committee whenever requested to remain transparent with the City Council and the public in our approach to our healthcare cost savings goals. Thank you for the opportunity to testify on our progress, and at this time I'll take questions.

CHAIRPERSON FERRERAS-COPELAND: Thank you very much. We will begin with a first round and then a second round. So members will be coming in and out. We've been joined by Council Members Cornegy, Dromm, Cumbo, Constantinides, Johnson. Several of the initiatives that you outlined as part of the savings related to improving the overall health of the City's employ--workforce. And in your most

recent Quarterly Report, you said that the healthcare expenses for cancer, heart disease, diabetes, and hypertension represent 40% of the total health spending, which you've mentioned in your testimony. Can you describe the state of the workforce health? What are the major chronic and acute conditions affecting our workers, and what do you know about mental health, and your biggest concerns going forward about the health of our retirees?

COMMISSIONER LINN: So I'm not clear to begin the answer on this one. (sic)

CHAIRPERSON FERRERAS-COPELAND: [interposing] Great thank you.

COMMISSIONER LINN: --I'll get--We'll have Claire do this one.

DEPUTY COMMISSIONER LEVITT: We're just beginning the process now of drilling down into the data to--to really examine more and more about the specific diseases that our workforce is experiencing. We do know that there is a high--a high degree of diabetes of hypertension of some types of cancers, and we're really beginning to look at that in detail, and I think that's part of what we have planned the next year of--of our research into this. We--we have

started to address the things that we know are most critical to address like diabetes, and that--that we can address that through both the Diabetes Prevention Program and through--and through programs like the Diabetes Case Management program that works with diabetics that have all--already been diagnosed.

CHAIRPERSON FERRERAS-COPELAND: So is there anything or what is your thought and your experience? You've identified that these are the chronic issues. You're trying to implement what is somewhat of a voluntary program for people to actively participate in the different types of initiatives that you have. What happens to the--if the workforce doesn't respond to the initiatives that you've laid out?

COMMISSIONER LINN: So let me start with that--and that's--because that's very much a collective bargaining issue. I think that we achieved things in the last several days that was never expected that the workforce would agree with the City to make the types of changes we now put in place. And I think we did it by understanding together that these changes were at one--on--on the one hand significant, but also could impact on making

the health of our workers better. I think we're going to discover the same thing with these chronic diseases and the analysis of that, and--and I want to point out again that we are analyzing data now in a way the city never did before. And, my view is that as we see where we can effectively improve care, we will work with the unions to figure out how to make it most effective, and--and how to provide care. Because the real--the union and management have the same interests in making certain that the workers are as healthy as we--as can be in an efficient and effective way. And so I think that those would be discussions. As Claire said, we've just begun this process and when people have talked about the agreement before, I've said, you know, we're only in year one of a four-year agreement, and then only in the beginning of year two of three-year rebate. (sic) You're beginning to see the type of things that labor and management can do together when they are working, when their paddles are going in the same direction, and that's what we're doing on this health benefit plan at this point.

DEPUTY COMMISSIONER LEVITT: I'd also like to add that really fundamental to our programs

is the idea that--that we're going to be offering these programs at the work site. We think that that has the best opportunity to be able to reach people, and--and get them to fit these types of programs into their--into their busy lives. It's--it's very difficult to go to programs that are after work or on the--or on the weekends. We all have--we all have crazy busy schedules. If we can offer it at the work site, we think we'll get better voluntary engagement in these programs than--than people get when they're just outside of the work site, and that's part of what we're studying is looking at are we getting better engagement, are we getting better results with our work site programs? And that's what--one of the things we're very excited about looking at.

CHAIRPERSON FERRERAS-COPELAND: And hopefully that mitigates the wait time because the challenge that a lot of work--the workforce has is trying to schedule and appointment even if it's for preventative or non-preventative care can take longer than usual.

DEPUTY COMMISSIONER LEVITT: So those are some of the reasons that we've looked at the--the online scheduling like with ZocDoc--

CHAIRPERSON FERRERAS-COPELAND: [interposing] Uh-huh.

DEPUTY COMMISSIONER LEVITT: --which enables people to get an appointment with--with a physician usually within 24 to 48 hours instead of--instead of waiting for days sometimes weeks to get an appointment and Telemedicine, which will enable you to have an immediate physician visit, even, you know, even from home, from the work site, you'll be to--you'll be able to access via phone or via online a physician immediately.

CHAIRPERSON FERRERAS-COPELAND: Yeah, well, I mean I think the positive also of ZocDoc is that it sends you reminders. So for your yearly checkup, your six months or three months you get a reminder via email. I've had personal experience with them, and actually it does help. So I want to talk about the HIP Premium rate. By--by hour or just the key determinant to--of health insurance costs to the city is a number of employees and dependents covered by the City funded health insurance and premium charged by HIP for that insurance. In New York State the HIP premium is subject to the approval by the State Department of Financial Services. Can

you tell us a bit about the process and the role of OR that OLR plays in it--in it?

COMMISSIONER LINN: In the rate setting, or in the

CHAIRPERSON FERRERAS-COPELAND: [interposing] Yes.

COMMISSIONER LINN: --or in the cost?

CHAIRPERSON FERRERAS-COPELAND: In the rate setting.

COMMISSIONER LINN: Well, the rate setting we work closely with OMB and that we generally submit a--comments each year as HIP sets its rate and that--that is part of the process that we have. We--we engage our actuary to help us in the analysis, and we make submissions and--and that's the annual process. There isn't more I can add on that. Ken, do you--can you add anything on that at this point?

KEN GARDINER: Process wise the--the insurers submits their--their rate filing to the Department of Financial Services. There's a comment period. As the Commissioner has pointed out, the City submits comments to the Department of Financial

Services, and then a final rate is approved and that's sort of the process.

CHAIRPERSON FERRERAS-COPELAND: On September 18, 2018, your office submitted comments to DFS opposing HIP's request for a 5.98% increase. With comments focused on H--HIP's financial statements and its relationship to other parts of the Emblem Health, but did not mention the efforts of the city and MLC partners to control costs, how is the savings achieve by the City and the MLC affect the HIP Premium rate that the City pays and why couldn't use the savings as an argument against the rate increase?

COMMISSIONER LINN: Well, actually we hadn't made any changes in the HIP plan before. All the changes I just described were in the--are in the GHI Plan except for this new HIP Plan, which was the first change we made. So that we very much are affecting the rate going forward based on the changes we just made three days ago. But before that we had not modified the HIP Plan.

CHAIRPERSON FERRERAS-COPELAND: Thank you and--

KEN GARDINER: [off mic] You had---had--you have more than half a billion in savings in there. [pause]

CHAIRPERSON FERRERAS-COPELAND: So, the--your half a billion savings how does that relate to your HIP Plan? If you have--you've identified now a half a billion in savings, is that correct.

KEN GARDINER: Half a billion in savings due to lower than expected HIP rate.

CHAIRPERSON FERRERAS-COPELAND: Due to a lower than expected HIP rate?

COMMISSIONER LINN: Yes. So, and I need to go back to the Labor Agreement we reached in '14. The issue always in labor negotiations is how much you can afford to pay, what should be the wage increases and can they be afforded. The process in New York City, which is a process I've been involved with in--all during the late '70s and ;80s and the away from for 24 years and now I've returned to it again. The process is searching through the budget, finding whether dollars are available to support wage increases, and that's generally a process that has been in place for decades as a negotiating process. In '14, the issue was how much could be afforded as

part of very complex labor agreements whereas you know that a 150,000 of the workers had not received the two four percent increases the other 200,000 had--had received, and it was very difficult to figure out how we were going to put together all of the elements to create a financial package. One of the things that we inherited was a financial plan, a budget and financial plan that projected the cost increase, the annual trend rate increases for HIP would be I think a 8-1/2 or 9% per year. And so, that was in the budget at the time we negotiated the settlement, and the question for making the settlement was are there a possible savings from the budget and financial plan? And we said as part of that savings, as part of that settlement that if we can identify savings so that if HIP were at a lower rate, then those would be savings, and those savings could be part of the general overall healthcare savings that we are looking for because we identified $3.4 billion plus a billion dollars from the Stabilization Fund to support the Labor Agreement. So I know there have been a lot of comments about what should be credited or what shouldn't be credited. Those are by people who weren't part of

the negotiations. We were very clear from the beginning that if the HIP rate was lower than 9%, that would provide a savings for the $3.4 billion. Had the HIP come in at over 9%, that would have been a cost that had to be made up for in this bargain. We have been fortunate for the last two years that the HIP rates have been less than projected. A lot of people are uncomfortable with where healthcare costs are going, going forward. If they go higher then that will not provide savings, but the important is when we made our settlement clear it was the financial plan that we inherited from the last administration. That was driving our costs, and if healthcare costs saved $3.4 from those projections, those would be acceptable. Some of those entailed lower HIP rates. Others entailed some dramatically important changes in the plan design, which we talked--which we presented to day.

CHAIRPERSON FERRERAS-COPELAND: Thank you. As we had mentioned earlier on the Stabilization Fund it was created because HIP was cheaper and most of our popular--and the more popular option, but today GHI is a cheaper and more popular option. However, the city is still paying the

difference between GHI and HIP's rate into the fund. Is your office considering a reform that would amend the Administrative Code to allow the City to pay the less expensive and more popular GHI rate, and what determines the size of the contribution to the fund? What was the contribution this year?

COMMISSIONER LINN: So let's start with would we move unilaterally to make the change of the--in the Administrative Code? First, I think the Administrative Code provides that the city shall pay not more than HIP H--up to the HIP HMO rate, but the full--the full cost of health insurance up to the HIP HMO rate? I believe that what we have in this Stabilization Fund, and that approach has now been incorporated in our collective bargaining, has been part of the arrangements between the city and its workers for 30 some odd years. I think it would be difficult to turn around and say oh, well, we're not following that any more. I think that the process that has worked very well is being a collaborative effort with the labor unions to find savings, and we are doing that. As you notice, we are using the Stabilization Fund together to do many important things. There is $60 million coming to the city as

part of this. The City--the Union has used it to enhance the Welfare Fund given the high cost of prescription drugs. We have used it to support some of the programs that we've been talking about. The Stabilization Fund is there and constantly talking about--talked about. I think that the use of the Stabilization Fund is now very different from what it was two years ago. We will constantly about what is appropriate? How to use it more effectively, and whether different approaches make sense.

CHAIRPERSON FERRERAS-COPELAND: Okay, what determines the contribution, and what did we contribute this last year?

COMMISSIONER LINN: Ken, can you come up here?

KEN GARDINER: So the contribution as you described is--is the difference between the HMO rate and the GHI CVP rate. Basic---you know, in the end of the day, it's subtraction is the--the difference between those types of number. The number of--of contracts. There are some year-to-year anomalies in terms of the cashflow, but I would say, you know, over the last few years it's averaged about $6 to $700 million a year.

CHAIRPERSON FERRERAS-COPELAND: Now, you said that's an average?

KEN GARDINER: Yes.

CHAIRPERSON FERRERAS-COPELAND: Can you get back to the committee whatever the exact was for last year, if you don't--or do you have that?

KEN GARDINER: Last year in--in Fiscal 15 it was--it was only about $285 million, and that's partly just due to when we made cashflow--when we made the transactions. There's a--there's a process of calculating and getting these numbers in place, and when the--when the payments take place. So last year only a portion of--of what eventually and what we accrued was--was paid. But they'll be a larger payment this coming year because now the--the cashflow is catching up. That's why I gave you the average to start with, but the number for last year the actual cash paid in was--well, actually I'm sorry. It's--it's three--

CHAIRPERSON FERRERAS-COPELAND: I'm sorry. I didn't hear that last part.

KEN GARDINER: It--last year's number was $310 million because I forgot that. So there's one

other piece that for--for stabilization which is a $35 million a year annual contribution.

COMMISSIONER LINN: And--and--that's actually the contribution that I think stems back to 1985 or '86. Somewhere in the '80s.

KEN GARDINER: We negotiated 25. We added that in the kitty. (sic)

COMMISSIONER LINN: Oh, I see.

CHAIRPERSON FERRERAS-COPELAND: Okay. So can you--just for the committee if you can share the process with payment timelines, what's--what's triggered the $35 million. When did it--it went from 25 t 35? If you can just share that with this committee, it would really be appreciated.

COMMISSIONER LINN: Sure.

CHAIRPERSON FERRERAS-COPELAND: Thank you. I have one more question before we begin our second round. Ninety-percent of the City's employees are insured by either HIP or GHI, both of which are part of Emblem Health. When the two firms merged in 2006--and I know this is--it pre-dates this administration--the City sued concerned that the merger would lead to higher rates due to lack of competition in the industry. Is this still a

concern, and should the City as--and its partners in the MLC look to expand the relationship with other firms?

COMMISSIONER LINN: Well, that's a very interesting and important question, and ones that we'll think--

CHAIRPERSON FERRERAS-COPELAND: [interposing] So did I. (sic)

COMMISSIONER LINN: And we'll thank you and one, we're thinking about, and again this is something that requires bilateral conversations with our--with our unions, but it's--it's certainly something of interest and something to be thought about.

CHAIRPERSON FERRERAS-COPELAND: Okay, thank you. I will now open the mic over to my co-chair and then we will hear from Council Member Crowley.

CHAIRPERSON MILLER: Thank you Chair Ferreras-Copeland. Very insightful. I kind of want to spare you on--on the HIP rate, and I think we talked about this in last year's hearing, and partially follow-up of that last question as to--since the merger and why, in fact, that rate is still

relevant, and why, in fact, we would be using the HIP rate exclusively, and is there any chance that-- In fact, is there a reason why we--as you said, that we changed the process to private because it was antiquated and we were not taking full advantage of- of the--the program, and the funds. We are not also taking--haven't been--have not been taking full advantage of access to all of the potential providers there. First off, I want to talk about the rate, and while we're still using that HIP rate.

COMMISSIONER LINN: Sure.

CHAIRPERSON MILLER: [off mic] Can you explain that.

COMMISSIONER LINN: So I--I was--you're having the benefit of a person was involved in those first negotiations back in the--in the '80s and--and at the time view was that HIP HMO, that a-- is a well managed plan and would be a driver of low-cost coverage, and that the GHI as a fee for service type plan would likely be more expensive. And using the benchmark of a HIP HMO rate that that would be very effective in keeping healthcare costs down. And I think has been effective, and was effective for many years, and I have to say the overall cost of City

healthcare is not off the charts in comparison to many--many plans as you look around the country, but we can make improvements on them. And so, the--using the HIP HMO as the benchmark is something that did make sense, and something now needs--that needs to be reconsidered, but I'm not certain where--where it goes. I do know that we'll be back in collective bargaining in the next year or two, and in collective bargaining we want to look at healthcare benefits again. And the last time our approach to these issues was to establish $3.4 billion of savings in a program to work together. What our approach looks like in the next round of collective bargaining, there are things we need to think about and need to develop, and things we'll present to the labor unions at that time. But clearly healthcare costs remain a--an important focus of our conversation going forward.

CHAIRPERSON MILLER: So considering that Emblem shared in the industry particularly in the terms (sic) of HMO, is it--do--do we think that--that continuing to use that rate--is that the rate that's driving the market considering their share? Is it conducive to the City that we use that and they may

not be the player that they was when this agreement came in fruition?

COMMISSIONER LINN: So I think those are all things we need to think about as we enter the next round of bargaining of what the City's approach should be in terms of how we pay for healthcare costs.

CHAIRPERSON MILLER: So, this--on--on--you mentioned about the collab--and I'm--I'm so glad to hear that there is collaboration obviously between labor and management. It is something that has been sorely lacking for a number of decades around the city here. So I'm really glad to hear that, but what portion of the delivery of services actually require an agreement between labor and management?

COMMISSIONER LINN: Are you talking in health--healthcare?

CHAIRPERSON MILLER: Absolutely.

COMMISSIONER LINN: [pause] Well, I think in healthcare if we were to modify what our benchmark costs would be, I think that probably would be a--a collective bargaining issue, and the use of the Stabilization Fund, are clearly an--an issue. Design of plans. I know the last administration had

a much broader view of what the Administration could do vis-a-vis healthcare plans than we have ever exercised, and that led to a number of litigation efforts in court, in arbitration and for the most part, the unions were successful in those efforts. We have decided that it makes much more sense to try and work together to solve these problems than to litigate out what we can and can't do. And that will be the approach of the Office of Labor Relations and the Administration going forward is that we won't-- won't explore some of these questions as the prior administration did. Rather, we'd like to reach concrete collaborative settlements with the workforce.

CHAIRPERSON MILLER: Okay, so I--I think in--in short I was saying that--that we renegotiate, the union would negotiate the benefit and some semblance of the design, but not the provider. Is that correct?

COMMISSIONER LINN: So again I think that it's a process that we're going to do across the table, and that I--it would just not be correct to say that we are going to do X or Y in this proceeding. I believe that we will with the unions

figure out the most effective way of delivering healthcare services.

CHAIRPERSON MILLER: Okay, thank you so much and that is--that is refreshing to hear. So you talked a lot about data analysis--

COMMISSIONER LINN: [interposing] Yes.

CHAIRPERSON MILLER: --right, and what that data enabled you to do in this year's negotiations in--in terms of that. What did you do in the past? This is not new data. This is--a lot of this stuff that I'm looking now--looking at now was pretty much industry standards, and things that I've looked at as a trustee for the last ten years. I-I know that the city wasn't that far behind. Is there a reason that you could not access this data?

COMMISSIONER LINN: So when you say what did you do, I had the exact same experience you had. In all of the work that I did before I came to the City, employers and employers in unions would look at this type of information together and would make informed judgment. When we got here, there was no data analysis?

DEPUTY COMMISSIONER LEVITT: There are no data analysis.

COMMISSIONER LINN: No data analysis that--that was conducted by the City, and that we then entered into discussions with the unions about how to get the data to make sure that confidentiality would be protected, and that we could then look at data together, and that was again I think another important breakthrough in terms of the arrangement we've set--we've--we've now entered into is that labor and management together are doing things that most employers have done for years, but the City of New York didn't.

CHAIRPERSON MILLER: So was the provider not releasing the data, or we were just not looking for it.

COMMISSIONER LINN: I think there was a debate over whether or not the data could be provided to the city alone or whether required joint agreement, and the unions were against sharing that data until we had agreements about it. And so the data was not provided to the city, and I think it's another example of the--the approach to try and act unilaterally wound with the City not having sufficient information, and now working collaboratively we do have the information.

CHAIRPERSON MILLER: Wow.

CHAIRPERSON FERRERAS-COPELAND: That's great.

CHAIRPERSON MILLER: That is interesting. So, I know that last year is we--we--you--you were new, and we talked about some of the things that are actually happening now, and we talked about the ability or lack of to address the plan design issues. So, in--in addressing those plan designs there's two things that we're about. We're talking about savings achieved as well as providing a more efficient service and benefit to--to the membership. Do you think that we have maximized--with what we've seen now, are we maximize--have we maximized that or as you indicated that there's still a lot of conversation--more conversation as to how we can be more efficient in delivering a better product?

COMMISSIONER LINN: I mean my--my sense is there's plenty more to do. That we have begun really important work together, and we will identify new things going forward, but we're certainly not at the end of looking at plan design.

CHAIRPERSON MILLER: So to kind of go to the HIP HMO, piece and the Advantage Care, what is--

what percentage of the employees are enrolled in the Advantage Care, which are essentially the HIP centers right?

COMMISSIONER LINN: The--well, the Advantage Care is part of the GHI Plan [coughs] and we at this point we're just starting it, right. So I'm not sure what the percentage is.

DEPUTY COMMISSIONER LEVITT: Right now there's some utilization of the Advantage Care facilities, and they're available right now.

CHAIRPERSON MILLER: [interposing] What facilities?

DEPUTY COMMISSIONER LEVITT: They're available right now. There are 36 locations around all the boroughs. The--the utilization has not been as good as we hoped it would be, and we do think that there--that there is great quality care there, and cost savings from better care coordination that's offered at those facilities. So we're hoping that by offering a zero co-pay, we will get more people to utilize those facilities.

CHAIRPERSON MILLER: Okay. So, the--is--is--is the Advantage Care GHI Centers operated

separately from the HIP centers. Do--do they still operate the HIP centers, the---

DEPUTY COMMISSIONER LEVITT: No, the Advantage Care facilities are-- are the--the current iteration of the HIP facilities.

CHAIRPERSON MILLER: [interposing] Uh-uh.

DEPUTY COMMISSIONER LEVITT: They've been updated. They are now what are referred as medical home facilities, and they are, you know, and--and they are offering what the HIP facilities used to offer?

CHAIRPERSON MILLER: Do they have the same number of--of centers, do you know, or comparable?

DEPUTY COMMISSIONER LEVITT: They have even more centers?

CHAIRPERSON MILLER: They have more?

DEPUTY COMMISSIONER LEVITT: They've added more centers. In fact, they're going to be adding a--a center right in the downtown area next year, and they are adding--they are looking at adding around the boroughs as well.

CHAIRPERSON MILLER: So you over the years--have you found--have we found a--a significant

savings in utilizing the centers as opposed to individual healthcare providers?

DEPUTY COMMISSIONER LEVITT: Emblem Health tells that there are significant savings at the--at the Advantage Care facilities, and they have actually guaranteed for us that by offering the zero co-pay to incentivize more people to go to those facilities, that our costs will at least be stable if not go down. So, certainly, we'll--we'll be looking at the trends at--at the Advantage Care facilities going forward.

CHAIRPERSON MILLER: So as--as we examine data, and I know that in the past that we had and-and--and you mentioned that this data didn't exist, but obviously there was some industry data that exists because I know that--that the City had procured healthcare consultants consistently that could provide some semblance of this data. And it--it kind of should have been double, but who will be monitoring this to--to know, and I'm going to give you a experience of my senior retired parents, and -- and others in--in the districts who have historically gone to a--a center that in the past year the center has lost three doctors and have not been replaced,

which means longer waits and all the things that had been corrected over the past--the last three or four years have kind of manifested themselves again. How do we as a city recognize that we're-that--that we're not receiving savings on the backs of, you know, our employees and retirees?

COMMISSIONER LINN: So let me say a couple things. First of all, we actually also had presentations by the healthcare consultants from the last Administration. And they did not have this data, these data that we're talking about. They were operating under sort of national numbers, general trends, but not specific data, and so the data analysis is new. As extraordinary as it may seem, that is something that we've begun is the use of analysis. I do believe that--that what we have for each of these programs, and I want--this is what I really wanted to convey was the ability to look at what program work. Do wellness on site work? And--and to analyze. Do-are the Advantage Care programs--programs able to save money, and Emblem believes and sufficiently that they're saying that they'll better even though there's no co-pay. Maybe using co-pay change will incentivize a number of workers to uses

these--these--these clinics so that they do better in the--in the future, but we'll know, and we will know as a labor management team, and we'll be able to see are we getting savings from it? Are we not? Are savings exceeding what we projected or less than what we projected? Those are all things that we will know, and we look at it, we'll be able to make decisions and we'll report on them in our--in our reporting.

CHAIRPERSON MILLER: I just--I hope that there's a mechanism to--to--to ensure that we're getting the bang from our buck that we deserve. So I this plan design are we going to see an expansion of the system--of the system itself, not necessarily in terms of expanding the net worth in terms of number, but in--is it going to maybe New Jersey or into another county that we have not been able to provide a service to many City employees?

COMMISSIONER LINN: We don't have it?

DEPUTY COMMISSIONER LEVITT: [off mic] I don't see. (sic)

COMMISSIONER LINN: [off mic] Well, this is what ACPs I guess we're operating outside of the--of the --do you know?

DEPUTY COMMISSIONER LEVITT: I have to--I don't know the--I don't know the answer to that. That's something that we can take up with Emblem Health.

CHAIRPERSON MILLER: Does this address the gate keeper referral issue? Does that remain as well?

DEPUTY COMMISSIONER LEVITT: In the HIP HMO, there is--there is a gate keeper process through the primary--through the primary care provider. In the--in the GHI Plan--

CHAIRPERSON MILLER: [interposing] It was not in that plan?

DEPUTY COMMISSIONER LEVITT: --there is no--there is no gate keeper process.

CHAIRPERSON MILLER: Okay, okay, thank you so much. I appreciate your answers.

CHAIRPERSON FERRERAS-COPELAND: Thank you, Chair. Council Member Crowley.

COUNCIL MEMBER CROWLEY: Thank you to both our chairs today. Good afternoon. I have a few questions. First, it seems like the--the greatest saving in the budget here are the monies that were overestimated in terms of the cost of the plans

between the $537 million and $85 million. That's correct?

COMMISSIONER LINN: So that is correct. On page 27 on the exhibit it shows that those are the--of the billion dollars those are the numbers. That $600 million comes from those.

COUNCIL MEMBER CROWLEY: Yeah, so that money--all this, overall nearly--a little bit over $1 million in savings. It's monies that the City put aside not 100%. It's--it's money also that's coming from the workers contribution to the healthcare plan as well?

COMMISSIONER LINN: These are contributions that through collective bargaining the City is obligated to pay.

COUNCIL MEMBER CROWLEY: I just wanted for--for--

COMMISSIONER LINN: [interposing] Yes.

COUNCIL MEMBER CROWLEY: --for clarification. It's monies that come from the workforce as well as what the City is putting aside.

COMMISSIONER LINN: When you say the workforce, it's on behalf of the workforce. There--there are city cont--

COUNCIL MEMBER CROWLEY: [interposing] Well, I'm seeing-

COMMISSIONER LINN: --there are no employee contributions.

COUNCIL MEMBER CROWLEY: Out of--why do the City employees have to pay towards their healthcare plan?

COMMISSIONER LINN: They do not. These payments to the Stabilization Fund has no impact. The city payments for--for health--for instance if they take high option health writers that doesn't impact on this. Or, if they make co-pays, it doesn't impact on this. This is purely the difference between the HIP HMO rate and the GHI rate. That's what--that's what funds and these are city dollars that go into the Stabilization Fund that are obligated to be paid through collective bargaining.

COUNCIL MEMBER CROWLEY: Right and through the collective bargaining employees are obligated through the plan through whatever plan that you agree to, they're obligated to pay towards their insurance.

COMMISSIONER LINN: Well, they're not obligated to any payroll deduction. They have

certain co-pays. Unless they--unless they are in the--the five to ten percent who--who exercise--use plans who are more expensive that the HIP HMO rate. But all those who are in GHI or HIP do not have a payroll deduction for their healthcare costs.

COUNCIL MEMBER CROWLEY: Okay. My concern in this plan is a very large allocation of cost savings has to do with the co-payments that are changing, specifically the hospital co-payments. I know a lot of my constituents that have kids that suffer from asthma are in those emergency rooms quite often, and that when you have a co-payment of $50 going up to $150, a parent on a very tight budget may think twice about going into the emergency room, and that is a big fear that I have with your cost savings here.

COMMISSIONER LINN: So let me say a couple of things about that. First of all, the emergency room co-pay of $50 was--was almost unique in--in-in plans public or private, and that if again if you look at the Kaiser numbers, I think the average emergency room co-pay is $150, $175 or $200. So we are--with a plan that is very similar to most--to most plans. But the point, though, of ZocDoc, and

the point of having an--an individual to have primary physicians that they can go to, and urgent care is still $50, not $150.

COUNCIL MEMBER CROWLEY: Right, no, I--

COMMISSIONER LINN: [interposing] And so there are other alternatives--

COUNCIL MEMBER CROWLEY: [interposing] but in a world--

COMMISSIONER LINN: --but using it--but using the emergency room is probably the most inefficient and--and--

COUNCIL MEMBER CROWLEY: [interposing] I get that--

COMMISSIONER LINN: --and not a very good result.

COUNCIL MEMBER CROWLEY: --you get that, but in the world where people are living like our city employees are living week-to-week, paycheck-to-paycheck, they're not as organized as people who have the ability to plan weeks in ahead--ahead of time to go to their primary care physician and to plan out their healthcare over their lifetime.

COMMISSIONER LINN: [interposing] So that--

COUNCIL MEMBER CROWLEY: I mean it has everything to with socio-economics, and too many of our City employees don't have that benefit just because they have so much on their plate. Another area--

COMMISSIONER LINN: [interposing] I will respond to that because--because that's exactly why we waited until July 1st to implement these changes.

COUNCIL MEMBER CROWLEY: It takes a long time to change a lifetime.

COMMISSIONER LINN: Oh, I don't know. I--I--my hope is that in four months--

COUNCIL MEMBER CROWLEY: [interposing] Look, my--my fear is I just don't want the neediest of New Yorkers thinking twice about getting the healthcare that they're entitled to because of the increase in costs that it--they will ultimately bear, but it looks like a savings that we're achieving, but--but ultimately the City employees will be paying for it. And another frustration I have here is 20--nearly a $21 million the drug plan meaning pre-authorizations. I mean I personally had this experience with a drug that one of my doctors wanted to get, and here I am nearly six months after seeing

that doctor still picking up the prescription because you have to go through a lengthy process of getting the pre-authorization. My doctor doesn't want to call GHI. GHI doesn't want to authorize the drug, but it looks like we're going to be doing more of the same of that. And that's another where I have a concern because it's just becoming too burdensome and difficult for people who are paying for their healthcare through this work and through this contract, and then now they're going to have another hurdle and another obstacle to getting their care. So I have a concern about that. I think we need to make it more accessible. If a doctor says a patient needs a drug, we need to make sure that they're getting the drug that they need, and having to jump through hurdles and getting more and more authorizations from GHI.

And then another area where you're saving $62 million it looks like there will be changes. That's the--the first one, the funding structure change in the City's GHI plan, it looks like there'll be a saving based on lowering the administrative cost. Does that mean that, you know, employees of the city will have to wait longer on the telephone,

or how--how is the savings so high being achieved in that line item? Funding, structure change in the City's GHI funds. (sic)

COMMISSIONER LINN: I mean so these are primarily I think debt savings. Let me let Ken talk about it.

KEN GARDINER: The--the savings from the restructuring plan is--is primarily from switching to the minimum premium plan which we put in place last year. And the--the principal savings there are some slight administrative savings just because it's easier to--to operate on minimum premium plan, but the--the primary savings comes from tax savings. The portion of the premium that--that--that is taxed when you go to this minimum premium arrangement it's far smaller, and we save state taxes. That's probably 95% of the savings.

COUNCIL MEMBER CROWLEY: What--what other co-payments are there? I'm curious--curiously--sorry--I'm curious to know if when a woman goes to a gynecologist is that an ACP specialty or is it an ACP general? I'm just curious like will the co-payment increase there or will it be a new zero co-payment?

DEPUTY COMMISSIONER LEVITT: Well, if it's a--if it's a well woman visit under--under the--the new provisions we have, it's going to be considered a free preventive--

KEN GARDINER: [interposing] Right.

DEPUTY COMMISSIONER LEVITT: --visit. Whether it's an ACP physician or not, it will be considered a free preventive visit.

CHAIRPERSON FERRERAS-COPELAND: Just as a follow-up and, of course, Council Crowley will continue her questions, OBGYN, because I know that when you're pregnant, you go every month, often times every two weeks depending on whether it's a risky pregnancy. So where would that fall in? [pause]

DEPUTY COMMISSIONER LEVITT: I think it's--I think that's 15--it's $15 visit.

CHAIRPERSON FERRERAS-COPELAND: That would be a $15?

DEPUTY COMMISSIONER LEVITT: Or--or zero if it's ACP.

CHAIRPERSON FERRERAS-COPELAND: $15 or zero?

DEPUTY COMMISSIONER LEVITT: $15 or zero.

CHAIRPERSON FERRERAS-COPELAND: Okay, thank you. Council Member.

COUNCIL MEMBER CROWLEY: I have no further questions. I just want to emphasize again the $150 for a hospital visit concerns me greatly. Thank you.

DEPUTY COMMISSIONER LEVITT: I--I think in--in response to that, I just want to mention that if--if someone is admitted to the hospital, the co-pay is waived. And, you know, what we're hoping--you--you raised the issue of--of an asthmatic child. What we're hoping to see happen is--is that our employees will go more to primary care. If the asthmatic child is being properly monitored by primary care physician, taking their medications, we're really hoping that they will get the--the--the care that they need, and not end up in the emergency room. One of the reasons that we've added much more intensive case management is to reach out to those families that are having constant chronic issues like that. So that we can make sure that they're getting the right kind of care so that they're not ending up in the emergency room.

CHAIRPERSON FERRERAS-COPELAND: Thank you, Council Member Crowley and, of course, as a--a a follow up, you know, I'm a--a mom of a very young child and every parent's nightmare is that you have an emergency. So it just seems that now it is more costly, and I would--I would hope that this doesn't encourage or an obstacle to parents taking their children to the emergency room because you'll have a $150 bill. If a child falls and you really don't know what's going, and in any other case you would take him to the emergency room. But in this case, you may now be apprehensive where $50 was a little bit more, something that you may be able to fit into your budget, $150 can be a very big challenge for parents. So I mean I--I think that--yes.

COMMISSIONER LINN: And so yes and I--I-- we understand that, and I think, though, it is important to recognize that the emergency room is generally not the best place for an individual to receive the healthcare. And that it is our hope that we will change behavior and that employees will use primary care physicians, will use preventive care, and--and that that will be successful. It's

something we'll--we'll find out over time of whether that is working.

CHAIRPERSON FERRERAS-COPELAND: Okay. You--in your agreements reached of 95% of the workforce, as you stated, can you comment no recent settlements and the status of the unsettled agreements? And, can you comment on the PBA, and where we are with the PBA? Are they included in the 95%, are they not?

COMMISSIONER LINN: Yes, the 95 includes all those groups that we've reached settlements or had an arbitration award for. So they are included in the 95% since we went through and reached a conclusion to our arbitration. We are back in discussions with the PBA again right now, and have meetings, and we'll continue to meet with the PBA, and hopefully we can find solutions for the balance of the--the seven-year contract period. As to the rest of the workforce, many of the--the workers in that other five percent are at CUNY, and they are both DC37 and the Professional--Professional Staff Congress. They represent I think at least 1-2/2 to 2% of that 5--of that 5%, and then beyond that there are a number prevailing rate unions that are also

having discussions with us, and I think the other large group is Emergency Medical Service Union that we are currently negotiating with.

CHAIRPERSON FERRERAS-COPELAND: So of the remaining 5% you're in current negotiations with all of them?

COMMISSIONER LINN: Oh, yes. Oh, yes.

CHAIRPERSON FERRERAS-COPELAND: I want to talk about the Retiree Health Benefit Trust. How does the Retiree Health Benefits Trust interact with the Health Insurance Premium Stabilization Fund? Do we pay the difference between HIP and GHI rates for retirees into the Health Insurance Premium Stabilization Fund? Retiree Health Benefit Trust.

COMMISSIONER LINN: I think you better take that.

KEN GARDINER: The--the Retiree Health Benefits Trust pays the cost of retiree health and welfare. So this normally would be a-a PAYGO cost for the City, but instead flows through the Trust. But if the question is how will retirees, and what's--how do they impact stabilization, then the--the answer is that if they're--if they're under 65 they--they have the same policies as--as our active

employees do, and they are treated the same for stabilization purposes. However, the--the senior care, that's the Medicare wraparound that it doesn't go through the stable--the stabilization process at all. So that we--we--we pay the GHI senior care rate on behalf of those employees and that's--that's pretty much the end of the line. There's no equalization like there is for the active--

CHAIRPERSON FERRERAS-COPELAND: [interposing] So whatever the rate--whatever the rate is that's what we pay?

KEN GARDINER: We pay the GHI senior rate and I think there are some--there are options, which--some of which have, you know, you have to buy up to--to some of the other options.

CHAIRPERSON FERRERAS-COPELAND: Okay. I know that you talked about, and referenced it again with Council Member Crowley, but it's the reason why you're waiting until July 1st to make these changes. Now, how--and--and you talked about innovation in some other categories for the savings. Are you planning to engage with the workforce differently to get information out? Because it seems that in the past there has been a process. Some find it weaker

or not necessarily satisfactory to communicate with workers. So how--what are the commitments to engage with workers in a different way? And while I understand the ZocDoc, and the telemedicine is important, we have to also recognize that some of our employees are not technologically savvy. So by--what--what is the process or what has been the commitments to get this new--or get the workforce informed of their options by July 1st?

COMMISSIONER LINN: So I--this is a process again that's part of the labor management process. There will be information going out from the unions and from the city, but I think what is different now is that we have the same group that agreed to these changes are now working on the communication process. And it is certainly my expectation that this will be better than ever done before by having the joint effort to get the communication out.

CHAIRPERSON FERRERAS-COPELAND: Okay. Well, the Council would love to work with you to make sure that we get some word out to our constituents also because we're all--we're on the other end when

they're frustrated and can't get help, and then we--you often--you know, we should have the information--

COMMISSIONER LINN: [interposing] Yes.

CHAIRPERSON FERRERAS-COPELAND: --so that we can give accurate up-to-date information.

COMMISSIONER LINN: Certainly. We'll work with you on that.

CHAIRPERSON FERRERAS-COPELAND: Yes. We're partners, remembers?

COMMISSIONER LINN: Yes.

CHAIRPERSON FERRERAS-COPELAND: Okay. Can you explain how healthcare savings for the CIG other than in--I guess is what you're calling the other entity. I know in the past from CIG will be a beneficiary of the savings but others will not. How do you make whole the CIGs, or the Cultural Institutions--I'm sorry. I know that--

COMMISSIONER LINN: [interposing] That's all right.

CHAIRPERSON FERRERAS-COPELAND: Who won't be beneficiaries of the savings and, you know, we want everyone included obviously, and this is a very important population group, and they provide very important services to our city. So where do the CIGs

live in these conversations, that are going to be benefitting from the savings, and those that are not?

KEN GARDINER: Well, the--the--the institutions that are in the City Health Plan will see a reduction in the--in their rates based on the--the savings that we've described today. How the--the non--the ones who don't participate in City Health, I mean it's a little different of the sale and to say that we maybe set an example of--of, you know, how savings can be obtained. I mean, I don't know if that's complete, but that's about all we can say.

CHAIRPERSON FERRERAS-COPELAND: But my--my understanding is that we are also imposing on the budgetary constraints if they're not. You know, they have to provide these health insurance. So we had budgetary conversations about possibly making for the whole for the difference, and now that we're beginning to cycle, do you see us eventually being able to make them whole?

KEN GARDINER: Right, I think that we have and will continue to the extent that savings comes to the city from these--from these savings, and not to the employers like the--like the CIGs. To the extent that we discounted our funding for collective

bargaining for these savings, which is what we did when we funded them, we will--we will continue to do that through our process so that--that if the City gets the savings, but we subtracted it from the collective bargaining then--then we need to get it back.

CHAIRPERSON FERRERAS-COPELAND: Okay, and when we--well, last year we had the challenge of it was kind of the timing right because you were negotiating and you were realizing your savings at a different time than us approving our budget, and the CIGs were left in a very tough position where they needed to make payments not knowing what the savings was going to be. So, how--do you see a potential difference in timeline, or is this something that is going to be perpetual because of--

KEN GARDINER: I--I think that--I think it should be here this year for the--for the '`6 savings, but certainly for the '17 savings. Having, you know, our plan largely in place, we should be able to make an adjustment early in the year, and you realize we--we basically came to you around this time last year to talk about FY15 savings. Here we've not only laid out the '16 but also the '17. So, we're--

CHAIRPERSON FERRERAS-COPELAND: [interposing] Right.

KEN GARDINER: --really--we're ahead as opposed to, you know, coming in at the end, you know, towards the end of the year. So doing the adjustment for '17 should be much earlier in the fiscal year.

CHAIRPERSON FERRERAS-COPELAND: Okay, thank you. Do--do you have some questions?

CHAIRPERSON MILLER: Yeah, I--I just had one or two. What are your premiums is the City paying toward the Emblem benefits? Are--are they the same at GHI and the other products?

COMMISSIONER LINN: For the FY16 individual rate for GHI annually it's $6,453. For HIP individual rate it's $7,236.

CHAIRPERSON MILLER: Oh, yeah.

COMMISSIONER LINN: Individual. For family GHI is $16,933, and HIP family is $17,729.

CHAIRPERSON MILLER: Okay, what if--what impact if any are these changes going to have on the other providers that small percentage of providers that exist?

COMMISSIONER LINN: Well, as I--as I would--as we're sitting here thinking about it the

HIP HMO rate will be reduced by about 1% but a little more than 1% based on the changes we talked about the HIP and that that will then drive through for the other providers that will lower the benchmark by 1%.

CHAIRPERSON MILLER: [beep] That's interesting. I--I think that--I--I--I think that we had this conversation last year, and--and we were very limited in--in speaking about that. So we've had a year for this to kind of evolve and think about how we could enhance those other--the--the--the benefits of--of--for those members who have those other providers for whatever reason. Often they have out of state--or large in that racial case (sic) they go out of school out of state or situations like that. And I'm hoping that we could--that maybe you want to spend a little portion of the city's savings on--on addressing that issues as well considering that on average some of the other--the providers that--those co-pays are not really--their costs are--they're not cost-effective. They are cost-prohibitive, and when you're spending almost $500 a pay period to have that benefit you're essentially seeing that those benefits shouldn't exist to a city employee because he can't afford to pay it.

COMMISSIONER LINN: So I--I believe that we have very, very strong healthcare programs that are provided to City workers without any payroll deductions. I believe that the types of changes that we've made were the changes that--that--that many, many criticized the city for not making, and they criticized us for only using the change in the HIP rate, and they said these are the types of changes that we should be making and we're not making them as a portion of the savings. But I believe that we continue to offer an extraordinarily good paid in full health program for city workers, and I believe the changes that we've made will incentivize better use of care.

CHAIRPERSON MILLER: So, of--of--so you're saying that--that by not investing in--or those other plans that you're kind of discouraging folks from using those?

COMMISSIONER LINN: I didn't get the last part of your question.

CHAIRPERSON MILLER: Are we looking to discourage folks from the other plans?

COMMISSIONER LINN: I think employees can choose whatever they want, but the--the fact that we

provide two excellent healthcare plans that are paid in full without a payroll deduction is a--evidence of very, very good care of the city workers.

CHAIRPERSON MILLER: So are we in particular on the GHI side? Will we be looking to expand those networks? There's a reason why people kind of go--gravitate towards those other plans in--in the limited amount. You know, and--and--and we want to be able to address those as well.

COMMISSIONER LINN: Because look, I think that we are constantly looking at how to make our health plans better, and especially if we can make them better while be more cost-effective, and those are things that we will be looking at.

CHAIRPERSON MILLER: Okay, so one of the things I would like to hear back from--from your office is in terms of the plans that are available when we said--as we talked about expanding that into other networks. I'm sorry, of--of--of the service areas outside of the--

COMMISSIONER LINN: [interposing] Yes.

CHAIRPERSON MILLER: --the--the ten counties or whatever it is that--that are covered?

How many counties are covered currently in the--do you know?

COMMISSIONER LINN: I don't know. I don't know, but we'll look at that, and we'll report back.

CHAIRPERSON MILLER: Okay.

CHAIRPERSON FERRERAS-COPELAND: Thank you.

CHAIRPERSON MILLER: Thank you.

CHAIRPERSON FERRERAS-COPELAND: Thank you, Chair. I just wanted to follow up on the 1% savings. In the--if--if we have the 1% savings on the--on the HIP side, and a worker decides to not take HIP, does--where is the difference, where is the difference found if there isn't the savings on the other side?

COMMISSIONER LINN: If the work let's say moves to GHI--

CHAIRPERSON MILLER: [interposing] Right.

COMMISSIONER LINN: --then that's--still the employee would have no payroll deduction and would see--would receive the same GHI plan that was modified by he current--the current changes.

CHAIRPERSON FERRERAS-COPELAND: Well, and insurance other than Emblem?

COMMISSIONER LINN: There, there would be a somewhat slightly higher contribution that would be necessary than if we hadn't made the HIP change.

CHAIRPERSON FERRERAS-COPELAND: A slightly higher. Do you know if--do they have to the--is it going to be more than 1%? Is it--?

COMMISSIONER LINN: It's just about 1% of the HIP rate so it would be--the Delta would be the 1% of the HIP rate.

CHAIRPERSON FERRERAS-COPELAND: If they go outside of Emblem?

COMMISSIONER LINN: Yes.

CHAIRPERSON FERRERAS-COPELAND: Okay. Thank you.

CHAIRPERSON MILLER: I'm sorry, is that--did we--so for those who opt into the high option rider, are they going to--are they going to be saving based on this, and I think you said that the answer would be yes.

COMMISSIONER LINN: That's no ride.

CHAIRPERSON MILLER: I think she just asked the same question--

COMMISSIONER LINN: [interposing] No, no the savings would less--

CHAIRPERSON MILLER: --and the answer is no.

COMMISSIONER LINN: --let's say if I'm using the numbers we numbers we used before with the FY16 HIP family rate is $17,729. If that were to go down by 1%, that's about $180.

DEPUTY COMMISSIONER LEVITT: Well, it's going to go up--

COMMISSIONER LINN: [interposing] No I understand.

DEPUTY COMMISSIONER LEVITT: --before it goes down.

COMMISSIONER LINN: Right, but because it goes up for the normal increase, but it would going up $180 more next year than it will under this agreement. So there would be a roughly $180 impact per year for family coverage in the example you gave.

CHAIRPERSON MILLER: [off mic] For the non-Emblem

COMMISSIONER LINN: For the non-Emblem plan of employees it should.

CHAIRPERSON MILLER: And it would absolutely be a deterrent considering they are already much higher premiums already. Much higher.

COMMISSIONER LINN: Well, there also will be--the contribution will go up by the HIP rate increase for the coming year. So, but it will be--it will be this 1% less, and that's why we're able to generate $60 some odd million dollars towards the health savings.

CHAIRPERSON MILLER: Yeah, but you only have--there's very few less than half--less than 10% aren't in the Emblem program?

DEPUTY COMMISSIONER LEVITT: Only about five percent.

CHAIRPERSON MILLER: Five percent. So I don't know how mucho of a difference that's going to make. In terms of the opt out program I see from last year we negotiated different rates. I didn't see that. How is that working? How many people aren't actually? How many people opted out?

DEPUTY COMMISSIONER LEVITT: We actually don't have all the numbers calculated for that yet. We didn't see as much as we hoped to see. We're going through all the different payroll information

that we got for this year I think we probably over-projected on what the saving would be, and that contributed somewhat to the fact that there was a gap in the 2016 year savings. We should have--by the end of the next quarter we'll have those numbers figured out, and we'll be able to report on that.

CHAIRPERSON MILLER: So, obviously opt is--would be equivalent to kind of the--the diva response, the same thing we--people aren't using the benefits. In that case, people aren't entitled to the benefit. But people who aren't using obviously there's a saving there. Are we getting out there and to the fact that you're doubling almost the--the amount for opting out that--that they receive?

COMMISSIONER LINN: That was in our calculation of projected savings would be the reduction in the--in the--the increasing cost of making the opt out, and then compare to what we thought would be the increased number of people who chose to the opt out, but that's in--but those again numbers where we're now gathering and we'll have a better idea next quarter.

CHAIRPERSON MILLER: Yeah, I was the same because after you said that you--that there's not as

many people as you had anticipated that opted out. I think you'd do a better job marketing considering. You know, I think that was one of the deterrents in the past that--why for that amount would I stay or would I opt out.

COMMISSIONER LINN: That's right, and--and that's--we're considering that and the issue of how to let people know about it, and whether we should do a better job is another thing we're thinking about.

CHAIRPERSON MILLER: Yeah, okay thank you.

CHAIRPERSON FERRERAS-COPELAND: Thank you, Chair. Thank you for testifying before us today. We have additional questions that we'd like to get to you. If you can get them back to the committee expeditiously, I'd appreciate it.

COMMISSIONER LINN: Sure.

CHAIRPERSON FERRERAS-COPELAND: Thank you very much.

COMMISSIONER LINN: Okay, thank you.

CHAIRPERSON FERRERAS-COPELAND: And we will call up the next panel.

COMMISSIONER LINN: Thank you.

CHAIRPERSON FERRERAS-COPELAND: We will hear from Maria Doulis of the Citizen's Budget Commission and George Sweeting from the Independent Budget Office. [background comments] That's all of them. [pause] Hello, you may begin. [pause]

GEORGE SWEETING: Now it's on, right? Okay. Good afternoon, Chairs Miller and Ferreras-Copeland and I guess the members of the committees. I'm George Sweeting, Deputy Director of the New York City Independent Budget Office, and I thank you for the opportunity to appear before you today. I should say my written testimony is a little bit out of date given some of the information that we received that we--we heard this morning. So I--I hope this is transcribed as delivered rather than as--as written. So, the Mayor's Labor--Mayor's Office of Labor Relations has previously reported that the City achieved its health insurance cost savings target of $400 million in Fiscal Year 2015, and has achieved at least some of the savings that needed to meet the $700 million target for 2016. Well, this is good news as far as the Budget is concerned. The savings achieved so far have less to do with controlling health insurance costs than with budget accounting

and one-time actions. The--I--I should say actually just as an introduction of--I'm joined by Marty Davis, who's IBOs Labor Economist. So the annual health insurance savings targets, which have accumulated value of $3.4 billion through 2018 were laid out in an agreement between the--the City's Office of Labor Relations, and the Municipal Labor Committee to achieve savings that offset some of the cost of the current round of collective bargaining settlements between the City and most of its workers. Reducing the City's cost of health insurance by improving the health of city workers and by finding ways to encourage workers to use less costly means of access--of accessing medical services were important objectives of the agreement. Some of the savings reported for 2015 stem from such efforts. These include $19 million from imposing stricter pre-authorization requirements on hospitalizations and diagnostic test, and more comprehensive case management for those with chronic conditions. And beginning in 2016, the City has introduced or expanded programs to help prevent diabetes among its employees, or to help those living with the disease manage it more effectively. Another new program

discourages use of emergency rooms for non-emergency cases through higher co-pays, and by offering employees referrals to alternative care options such as urgent care clinics and appointment with available eNetwork physicians. The City has also enhance the incentive payment that encourages City employees with access to health insurance from another source to opt out of that cover--of City coverage. An existing program that gives City employees online and phone access to nurses for consultations and advice prior to going to a doctor's office or hospital has also been expanded. At present, the City has not released, or at least until today, estimates of the potential savings from these and similar initiatives for 2016 and 2017. Clearly, such potentials--such changes have the potential to slow the growth of the City's health insurance costs while still providing access to a set of comprehensive benefits. But a large part of the savings achieved in 2015 and the savings that are expected in 2016 stem from changes that have more to do with accounting for differences between projected and actual expenses, and from removing some individuals from coverage who did not quality, and other one-time actions. None of which

bend the healthcare cost curve. There have been savings relative to what the City had budgeted in the 2015 adopted budget, which is the benchmark used for the OLR MLC agreement, but some of the largest items have little to do with the current and future behavior of--and health of City workers. Of the $400 million savings in 2015, $148,000 results from the decision by the MLC not to require the City to reimburse the Health Stabilization Fund after auditor overturned a Bloomberg Administration initiative that had used money from the fund to maintain parity between mental health benefits with general health insurance benefits from 2011 through 2015. Another big item is the $108 million in savings achieved by ending health insurance coverage for some dependents of City workers identified in an audit as not being eligible for coverage. There was no mention of attempting to recover the cost of the premiums paid in the past for these dependents. While it is good news that the City finally identified these cases, it is not clear that the averted cost represents savings that should count as part of a collective effort by the City and the MLC to alter the trajectory of health insurance costs. Two other terms--two other

items credit the savings that resulted in actual premium costs from both primary insurance for secondary coverage for Medicare recipients came in lower that the City--lower than the City had anticipated when the 2015 budget was adopted. Per the agreement with--between OLR and the MLC, such differences are counted towards the health insurance savings target. Although the savings amount--amount to a combined $55 million in 2015, they are expected to be much more substantial in 2016 and in subsequent years, and indeed today we learned that the savings will be $419--$419 million in 2016 and $622 million 20--in 2017 over half the amount of the savings in each year. The City's assumption--assumptions in June 2014 for health insurance inflation were higher than their healthcare trend rates implied by the Office of the Actuary's Other Post-Employment Benefits, or OPED estimates particularly in 2016 through 2018, the last year of the agreement. And you see the comparison between the budgeted numbers--the numbers that were used in the Budget in the table between and then the projections if you back it out from the OPED numbers and then what the actual numbers have been. At least in the first few years

of the agreement actual costs have been much lower than either set of projections. It makes sense that some savings from lower than budgeted health insurance premium costs should be credited the OLR and also the savings initiatives. But to the extent that some of the savings result simply from a too high assumption of health insurance inflation then it may not be appropriate to credit all of the savings to the agreement. I understand that the agreement allows but this--I think it's--it's worth thinking about whether, you know, these really represent changes in the behavior of--of City workers or in the costs of--of healthcare that--that are--that are the result of the changes in--in--in the way that benefits are packaged. Proper identification of savings that result from initiatives stemming from the OLR MLC agreement is important because under the agreement if the savings targets are not achieved there are additional steps that come into play including arbitration to choose from a menu of more onerous ways to meet the savings targets including employee contributions for health insurance. So thank you for the opportunity to testify, and I'm happy to try to answer your questions.

MARIA DOULIS: Good afternoon. I'm Maria Doulis. I'm the Vice President of the Citizens Budget Commission, a non-profit non-partisan fiscal watchdog in New York. CBC has been monitoring New York City's efforts to find health savings. CBC has long advocated negotiating changes to health insurance as part of collective bargaining, and applauded the Labor Management Agreement that committed to annual savings targets totaling $3.4 billion. As we have stated previously to this committee, the guiding principles of this exercise should be to bend the cost curve on rising healthcare costs and to account for any savings produced clearly and honestly. The results announced to date for Fiscal Years 2015, 2016 and 2017 get a mixed grade. While some worthwhile and significant initiatives have been agreed upon, the savings targets have been met primarily with savings from lower than anticipated premium rate increases not true reforms. The City and the MLC get high marks for changes that will reduce healthcares costs on a recurring basis. These changes are anticipated to save $477 million or 23% of the three-year savings that have been identified. The most significant of these changes is

the just announced transition from the existing HIP HMO plan to the preferred plan, which will lower the benchmarked premium rate and save the City an estimated $85 million in Fiscal Year 17. New care management programs for chronic conditions including diabetes are projected to save a combined $23 million in Fiscal Year 17. The City and the MLC also used a data driven approach to find savings in the GHI plan. The plan was converted to a minimum premium plan and new co-pays will be introduced to discourage over-utilization of emergency rooms, urgent care and specialists. These changes are expected to generate $147 million in savings in Fiscal Year 2017. The City and the MLC, however, get poor marks for claiming savings with an estimated $1.1 billion or 52% of the total from lower than projected premium rate increases, and I think George described these very well. Claiming such a large credit from the slowdown in healthcare inflation absolves the City and the MLC of the responsibility for continuing to make the changes necessary to fully modernize the City's health insurance plan. The parties have demonstrated they can work collaborative and productively to achieve the right kinds of savings,

reforms that reduce overutilization and have the potential to improve health outcomes for City employees. Finally, they get a mark of incomplete for $528 million in savings derived from other sources. These savings come primarily from terminating ineligible dependents following the conclusion of a long overdue audit, but also from funds taken from the Health Insurance Stabilization Fund or the HISF. The audit is a large source of savings, and it is important to gain authority to conduct such audits regularly as part of the managerial discretion. The HISF was established in 1986 with annual deposits made by the City to fund the difference between the HIP and GHI plans so that employees would not have to contribute to premiums out of pocket. The HISF is expected to be resourced in more than $200 million in savings announced to date. The fund was also tapped for $1 billion at the outset of collective bargaining negotiations in 2014, and will be used to fund preventative services at an annual cost of $48 million. Despite these large withdrawals, the HISF retains a balance well over $1 billion taxpayer provided funds. The City continues to contribute large amounts to the fund even though

it no longer serves its original purpose because the cost of HIP premiums has exceeded that of GHI since 2001. As part of their efforts to reform healthcare provision, the City and the MLC should work together to end further deposits by the city into the fund. And I should also note that the chair's line of question on the fund today divulge--divulged more than previously known publicly about the fund, and continuing to ask such tough questions I think will be important in--in considering what to do with it next. Thank you.

CHAIRPERSON FERRERAS-COPELAND: Thank you very much, and clearly, you know, we've asked them to follow up with their processes, and we will be sharing that publicly. It's something we talk about often and not knowing and not having transparency on where--what--what dictates the number, how does it change, and when do we decide. And I know that he testified to not necessarily recognizing that there is no need for reform that actually the funds have now grown into something else. But that was never the intent, and if there is something else then it should be called as something else and it should be done in a transparent way so we--we share your--your

vision and your and your well, questioning of the process.

MARIA DOULIS: Well, there should be a formal agreement to what that something else is at a minimum.

CHAIRPERSON FERRERAS-COPELAND: Other than what it is now, yes. Thank you very much. Thank you for coming to testify today. With no further questions, we will call this hearing adjourned. [gavel]

CHAIRPERSON MILLER: Well done.

CHAIRPERSON FERRERAS-COPELAND: All right.

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date March 12, 2016