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New York City Council Committees on Finance, Civil Service and Labor

Testimony by Robert Linn, Commissioner, Mayor's Office of Labor Relations

April 1, 2015

Introduction and Overview

Good morning Speaker Mark-Viverito, Chair Ferreras, Chair Miller and members of the Finance and Civil Service and Labor Committees. Thank you for the opportunity to testify here today.

I am joined at the table by Claire Levitt, the Deputy Commissioner for Health Care Cost Management and Ken Godiner, Associate Director of the Office of Management and Budget.

There has been a lot of confusion around the healthcare savings – so I truly welcome being here today to present this information to you. I want to point out that the nature of successful collective bargaining is not to discuss things publicly until there has been both agreement between the parties and approval by the membership – and this is made so much more complicated when you have 144 different unions and their diverging opinions represented in the Municipal Labor Committee.

As you know, the City and its municipal unions embarked last year on an unprecedented four year agreement to achieve $3.4 billion dollars in guaranteed cost savings aimed at bending the cost curve for New York City's health care programs. This is the result of changing the dialogue from one of confrontation and deadlock to collaboration and problem solving --- and it's great

news not just for the City and our workforce, but for NYC taxpayers and our long-term fiscal health.

We are here today to report on the successful progress of the Municipal Labor Committee and the City towards meeting these goals in the first three quarters of fiscal 2015, and our plans for the future. In fact, we have released today our latest report detailing the $400 million in savings secured for FY15, which I will discuss shortly.

Let me start by putting the labor - management healthcare efforts in the broader context of the de Blasio administration's collective bargaining negotiations.

When Mayor de Blasio took office in January 2014, every single contract with municipal workers had expired. In a little over a year, we've reached agreement with 76% of the workforce, both civilian and uniformed.

The administration from the very beginning was committed to a respectful and collaborative labor management program that solved the massive collective bargaining failure that we inherited, in a manner that was both fair to the workers and accepted as fiscally prudent by the financial monitors. In fact – all the agreements we have reached were ratified by the union membership by overwhelming majorities and have been universally applauded by the City's fiscal monitors as both prudent and solving a huge budgetary risk. For example, Standard and Poor's stated that with the labor pattern established last year, *"The City now has an element of certainty in its financial plan that it lacked in the past, when labor settlements and associated wage and benefit increases were unknown"*.

As part of that agreement, the administration committed to solving the intractable healthcare cost containment impasse that had developed in NYC for over two decades.

For the last two decades, while health care costs skyrocketed and employers all over the country adapted their programs, NYC did little to modernize its programs. City labor agreements require the City and the unions, represented by the Municipal Labor Committee, to agree on any changes to the health benefit plans. Collective bargaining strife precluded reaching agreement

over the challenge of rising health care costs, even as it became standard operating procedure for public and private employers to modernize their benefit programs.

The City of New York Administrative Code calls for the City to pay health insurance for all City employees and pre-Medicare retirees and families at the HIP HMO rate. This made a lot of sense historically when HMOs were considered to be the most cost efficient model of health care delivery with the lowest rates. In 1984, the City committed to make an equalization payment into a Health Insurance Stabilization Reserve Fund – jointly controlled by the City and the MLC -- representing the difference between the HIP HMO rate and the GHI PPO rate. This purpose was to provide funds to equalize the gap between the HIP HMO and the GHI PPO rates and allow employees freedom of choice between an HMO and a PPO, with both remaining free to employees at the equalized rates. What was never anticipated in 1984 was that the HIP HMO rate would become far higher than the rate for the GHI PPO Plan and remain higher, as it has since 2001. That obligated the City to make substantial annual payments to the Stabilization Fund and as a result, at the beginning of fiscal year 2015, the Stabilization Fund had accumulated over $1.7 billion dollars.

Meanwhile, in just the past ten years, the cost of providing health benefits to the New York City workforce doubled. In 2011, the Affordable Care Act further changed the landscape, requiring all employers to offer health care coverage with an expanded list of requirements like extending dependent child coverage to age 26, which was estimated to cost the City an additional $65 million per year. These new requirements provided important protections for consumers and employees but the additional cost was also borne entirely by the City.

Attempts by prior administrations to have the workforce share in the costs for coverage resulted in arbitration and litigation, which the City would typically lose as a result of the collective bargaining agreement. In 2013, the year before Mayor de Blasio took office, an attempt by the City to unilaterally go out to bid for a new health plan ended in litigation by the MLC and forced a retraction of the RFP by the City.

The de Blasio administration would not conclude its new labor agreements without addressing the critical issue of healthcare cost containment. And last May under this Mayor's leadership we achieved an unprecedented agreement with the municipal unions.

First, $1 billion dollars was released from the jointly controlled Stabilization Fund to cover part of the City's cost for the collective bargaining agreements.

Then we secured an agreement to have labor and management work together to generate cumulative health savings of at least $3.4 billion over the four fiscal years 2015 through 2018. By agreement, the plan did not specify exactly how the health care savings were to be accomplished, only that it would be done by a collaborative collective bargaining effort between the City and the MLC aimed at bending the health care cost curve.

So, in addition to the $1 billion which the City received from the Stabilization Fund, the four year plan is scheduled to secure $3.4 billion in healthcare savings -- at least $400 million for fiscal year 2015, $700 million for fiscal year 2016, $1 billion for fiscal year 2017 and $1.3 billion for fiscal year 2018.

The $3.4 billion is guaranteed by an arbitration process that will occur if the goals are not met. But the agreement with the MLC also stipulates that if the savings exceed the $3.4 billion minimum, the first $365 million of excess savings will go back to the workforce in a bonus payment – essentially a 1% bonus for the entire NYC workforce. If there are additional savings beyond that, the excess will be split between the City and the workforce 50/50. This innovative gain-sharing approach aligned labor and management's motivation to work together and fundamentally changed the labor-management dynamic around the common objective of identifying health care savings. The bargaining over the specifics of the savings approaches has been taking place in a collegial and cooperative framework. By sharing a common goal where we will all participate in the benefits of a positive savings outcome, we've moved the dialogue with the unions from one of confrontation and deadlock to one of collaboration and partnership that truly benefits the City, our workers, and NYC taxpayers.

So I want to take a moment here to recognize the efforts of all of the MLC unions and their leadership in this regard, especially Harry Nespoli, President of the Sanitation Workers Union and

Chairman of the Municipal Labor Committee, along with Arthur Pepper of 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 our health care savings goals has helped transform our vision into reality. The groundwork that has been accomplished in less than a year creates real momentum toward the four year $3.4 billion health cost savings goal -- and even the excess savings required to generate the shared component of the savings.

To lead the savings effort, the City created the position of Deputy Commissioner for Health Care Cost Management - a position that is focused on the issue of managing heath care costs, and it speaks to how differently this administration is approaching the challenge. Since the moment Claire arrived about six months ago – she has been 100% dedicated to making this unique labor agreement successful and I wish to offer my appreciation for all she has accomplished so far. She comes to us from a background in both labor and health insurance, having formerly been a Trust Fund Administrator for a large labor-management fund and President of a Care Management company. Her approach to pursuing savings has been in the context of the "Triple Aim" – simultaneously improving the health of the population, enhancing the patient experience and outcomes, and thereby reducing the per capita cost of care. Working within the philosophy that improving care goes hand in hand with generating savings, has also helped transform labor management contention into cooperation.

So here we are less than one year after this agreement was reached and I am pleased to report that we will meet the $400 million dollar savings goal for the first fiscal year of the new agreement. The current and future savings initiatives align with four different approaches we have adopted.

First, we aggressively attacked rates on all fronts --both State-approved HIP HMO rates that drive the premium rates, and the rates from our insurers and vendors.

Second, we are initiating audits of all of our programs. The first was a major undertaking to ensure that we were covering only eligible workers.

Third, we are looking at changes in the way health care is being delivered to our workforce to improve quality and make it more efficient.

Fourth, we are focusing on improving the health of the workforce, our families and our retirees.

All savings are being fully realized by the City. That includes savings from programs and initiatives that result in a lower amount actually paid for services, and savings from agreement with the MLC to lower the City's equalization payment to the Stabilization Fund.

There have been eight specific strategies that resulted in the $400 million savings for FY 2015:

We are releasing our third quarter fiscal year 2015 report today with detailed information on how we will achieve the savings. So, let me take you through the details now.

Fiscal Year 2015 Savings Detail

As you know, the savings are measured against the original 2015 -2018 budget projections, a quantifiable and logical metric for determining the savings. As we take you through a brief description of each of the initiatives that have already been implemented, it's important to appreciate that as many of them were implemented late in the 2015 fiscal year, they will have even greater financial impact in FY 2016. What's most important is that we are setting the stage for the future with many programs that will have recurring financial impact year after year.

- At the start of fiscal 2015, we changed the funding structure of the GHI medical plan, the plan which covers about 75% of the workforce for medical coverage. We changed from a fully insured program where all the risk was with GHI – something we paid more for -- to what's called a minimum premium plan arrangement. This results in significantly lower risk charges, lower administrative fees and positive tax implications, reducing the City's costs by **$58 million** this year with minimal additional risk.

- On hospital coverage, we negotiated a reduction of **$4 million** this year in Empire Blue Cross's administrative fees.

- To ensure that all health premiums reflected an accurate headcount, we went through an extensive audit to verify whether all dependents listed for City

employees and retirees were actually eligible. As a result, there were about 14,000 contract conversions such as changing from family coverage to individual coverage where significant savings were realized by paying the far lower health premiums for an individual. Total savings from this program is projected to be **$108 million this year.**

- In 2011, the City's plans became subject to the new federal Mental Health Parity requirements, which mandate that mental health benefits be equal to medical benefits. The last administration unilaterally concluded that the difference should not be counted in the HIP rate used for determining the equalization payment. The MLC filed for arbitration in July 2013. In October 2014 an arbitration panel ruled that the City had to include the costs of mental health parity in the HIP rate that was used to calculate equalization -- obligating the City to pay **$153 million** to the joint stabilization fund for 2011 – 2015. However, the Municipal Labor Committee agreed that the entire cost of this $153 million could be retained by the City to meet part of the FY 2015 health care savings obligation. This took a previously contentious collective bargaining issue and turned it into a win for the health savings program.

- To help control costs for hospital admissions, the City has had a hospital preauthorization program in place since 1992. However, it hadn't been updated since that time. Recognizing that more than 50% of all health care expenses are incurred by only about 5% of the population, and that 1% of the population is responsible for over 20% of the spending, it is common today in most labor and public and private sector programs to assign nurse case managers to assist patients with severe, high cost medical conditions. These care coordination programs not only save money but provide much needed assistance to employees and their families facing significant illness and hardship. So beginning March 1, 2015, the existing pre-authorization program was enhanced to provide a more

timely and comprehensive review of hospital admissions, and to provide nurse case managers for all patients with complex acute and chronic conditions, providing much needed assistance to employees, dependents and retirees with severe medical conditions. This will include patients with cancer, high risk maternity situations, transplants, HIV, and other conditions. In addition, a re-admission management program is being implemented to help ensure that patients have the services they need when they are discharged from the hospital in order to prevent unnecessary readmissions. These programs are going into effect late in the 2015 fiscal year and the savings are about **$15 million** in fiscal 2015. However, they are expected to produce savings of $50 million or more in 2016. In fact, substantial savings guarantees are being provided by the vendor. In addition, since the current program had not been competitively bid for many years, the RFP will potentially allow us to use new vendors and new approaches to even further enhance our savings. This is a change that we expect to have significant impact on bending the health care cost curve, while providing needed support to our employees with extreme medical needs.

- Another area of significant focus for health care cost increases is prescription drugs. Although the individual union welfare funds provide the basic drug coverage for union employees, the City provides coverage for specialty drugs – like biologics and injectable drugs. This is an area of extraordinary – and growing - cost. We renegotiated provisions of the specialty drug program to deliver substantial savings to the City. In addition, certain cost management provisions -- such as additional preauthorization and drug quantity management programs -- were added to enhance savings. Some changes took effect January 1, 2015 and others will take effect on May 1, 2015. The FY 2015 savings are **$7 million**, and the FY 2016 savings will grow to about $19 million.

- As discussed, the costs of the City's health care contribution for employees and pre-Medicare retirees is tied to the rate approved by the state for the HIP HMO. We vigorously disputed the rate increase requested by HIP for FY 2016 and we were successful at getting the HIP rate to be approved at only 2.89%. The budget prepared for fiscal years 2015 through 2018 assumed a 9% increase in the HIP rate each year, based on clear historical trends. This difference, as a result of the City's advocacy, will result in significant savings for FY 2016. The FY 2016 rate even has a modest impact on FY 2015 costs due to one agency with a different fiscal calendar, resulting in **$17 million** in FY 2015 savings.

- Likewise, the Senior Care premium rate increase for FY 2015 that was originally budgeted at 8% was finalized at 0.32%. That results in another **$38 million** of savings in FY 2015.

The impact of all these programs will generate the full $400 million savings in FY 2015 and set the foundation for the greater savings required in the future years of the agreement.

As part of our cost containment efforts, we are also looking at ways to combat some of the specific diseases that impact New Yorkers. Diabetes affects about 29 million people in the US and about more than a quarter of them don't even know it. It is the 7th leading cause of death in the country. We know that many of our employees are living with the profound health impact of diabetes. To help address this problem, we are implementing a case management program that specifically provides special support for patients with diabetes. This program is in the implementation phase and will start up July 1, 2016. Savings of at least $3 million in FY 2016 are being guaranteed by the vendor.

Finally, we are also implementing a program sponsored by the Centers for Disease Control aimed at preventing or delaying the onset of new cases of diabetes. Over a third of the population is thought to have pre-diabetes and are at risk for developing diabetes. The Pre-Diabetic

Prevention Program helps to identify people potentially at risk for diabetes and assists them in learning strategies to prevent the onset. Simple lifestyle changes have helped many people prevent or delay the onset of this disease. We plan to offer worksite programs as well as online programs to reach the widest number of employees and their families.

Creating a Culture of Health and Wellness for the Workforce

Unlike many other major cities, New York has not implemented any workforce wide wellness initiatives. So, we are looking at piloting a number of programs to encourage fitness, promote better nutrition, combat obesity, promote smoking cessation and reduce stress for the city's workforce. Many of these approaches won't have quantifiable savings we can specifically measure in the next year or two, but are a long term strategy to improve the health of the population and thereby reduce long term health care costs. Since so many of our employees stay with us for many years and continue their coverage with the City as retirees, our investment in their health is not only the right thing to do but also can have significant future cost savings implications. To support these efforts, we are going to be introducing an Employee Health section of the OLR website this summer that will provide valuable information and tools to help educate the workforce about health issues and our wellness programs.

The first health and wellness effort was the Citywide Flu Shot Program last Fall which provided free flu shots to all city employees and increased access by making the shots available at worksites and pharmacies as well as physician offices. With the support of Harry Nespoli and the Sanitation Workers Union, as well as Dr. Mary Bassett and the Department of Health, the program was kicked off at 5 am in a Sanitation garage in the Bronx last November where I was among the first recipients of the flu shot. The program resulted in 10,000 flu shots in November and December alone. Plans are already underway to begin the next year's flu shot program early in September 2015 to maximize its impact.

Ongoing Savings in FY16 and Beyond

As I noted before, many of the FY 2015 programs will have even greater impact once they have been in place for a full year in FY 2016, setting the stage for meeting and possibly exceeding the FY 2016 goal of $700 million in savings. I'll briefly walk through how the successful 2015 initiatives will carry over to 2016.

- The funding structure change to the City's GHI Plan to a minimum premium plan which saved $58 million in FY2015, is projected to save **$60 million** in FY 2016.

- The Dependent Eligibility Verification Audit (DEVA) which saved $108 million in FY 2015 is projected to save **$115 million** in FY 2016.

- The changes we've made to the Care Management program that will generate about $15 million in savings in fiscal 2015 are projected to save about **$50 million** in Fiscal 2016.

- Changes we made to the Specialty Drugs (PICA) Program in FY 2015 that are expected to save $7 million in FY 2015 are projected to save **$19 million** in FY 2016.

- The HIP Rate reduction that is generating $17 million in revenue to the City in FY 2015 that would have otherwise been paid into the stabilization fund for all active employees in the GHI plan will generate $335 million in savings for active employees and pre-Medicare retirees in FY 2016. The lower GHI Senior Care rate that is saving $38 million in FY 2015 will save **$42 million** in FY 2016.

- And finally, the Diabetic Management Program being implemented for July 1, 2016, is guaranteed by the vendor to save a minimum of **$3 million in FY16.**

- So, overall we expect already agreed-upon initiatives to generate as much as **$624 million** towards the 2016 savings goal of $700 million, putting us well on the way to meeting or even exceeding the FY 2016 goal.

Future Plans for Fiscal Years 2016 and 2017

While we are already well on the way to meeting the FY 2016 goal, we are also actively working in partnership with the unions to explore many new programs under consideration for FY 2016 and 2017. It's important to keep in mind that this is an ongoing process, one that is essentially an extension of collective bargaining. So it's too early to say yet which of these programs will be adopted, or how much the savings could potentially be. But by reviewing the types of programs we are exploring to bend the health care cost curve, we can give you an idea of the breadth and depth of the approach the City and the MLC are devoting to this effort.

- We are exploring strategies to reduce unnecessary emergency room utilization by increasing access to urgent care centers and primary care physicians. A few initiatives we're looking at include access to telephonic physician appointments, the ability to make on line appointments, and access to the 24 hour Nurse Line. We are also considering potential changes in copays to help lead to more appropriate health care choices -- so for example, we might consider raising the emergency room copay but lower the primary care copay to incentivize people to avoid unnecessary emergency room visits.

- We are looking to work with alternative health care delivery models like accountable care organizations and patient centered medical homes that emphasize a primary care focus. These models can provide access to the highest quality care and the best services for our workforce, especially those most at risk. With these models, the providers of care may assume some or all of the financial risk for patient outcomes.

- Having taken the step from a fully insured program to minimum premium funding, we plan to explore whether self-insuring the plans to further reduce risk charges and taxes is a viable option. Typically even plans much smaller than the City's will utilize self-funding as the least expensive option.

- We are looking at the possibility of expanding the pre-authorization requirements to include outpatient procedures like surgery and radiology to ensure that the city's workforce is getting the most medically appropriate care in the most appropriate environment. Most employers in the country adopted similar measures long ago.

- We are looking into the City's behavioral health program and exploring alternatives to improve access and quality of care. In keeping with First Lady Chirlane McCray's emphasis on improving access to mental health care, we want to be certain that our employees have the best quality mental health care, along with the best quality medical care.

- We are looking at potential changes in our opt-out program including the possibility of enhancing the existing incentives for employees and retirees with other coverage to opt out of the City's programs. Since the Affordable Care Act mandated that most employers have to provide health coverage, many of our employees' spouses and partners have other coverage from their employer, but opt for the City's coverage because there is no premium contribution. Likewise, many of our early age retirees take positions with other employers that provide health coverage but opt for the City's coverage because there is no premium contribution. We want to look at ways to encourage selection of other coverage when it is available and appropriate.

- For our retiree population, we are also looking at expanding Medicare Advantage program options, which can potentially provide even better coverage to retirees while capping costs for the City.

Conclusion

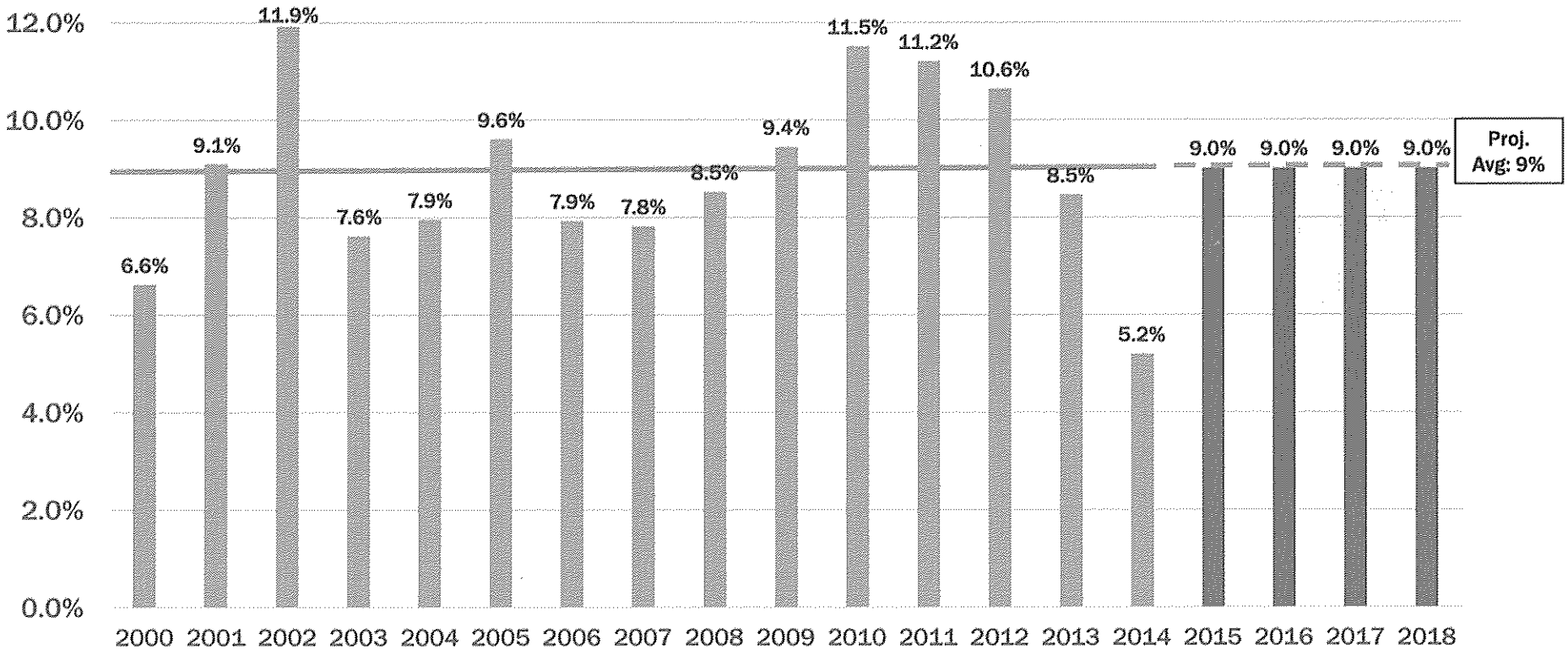
Looking towards the FY 2017 and 2018 goals, we are committed to continuing the work with the MLC to identify the right programs to improve the patient care outcomes, improve the health of the workforce, and meet our cost savings goals. We know that meeting the savings goals will require even more cooperation on everyone's part. However, building on the great success of the first year's efforts, we believe we are on track to meet and hopefully exceed the $3.4 billion healthcare cost savings goal. We are enthusiastic about potentially sharing savings with the workforce, along with our work to improve the quality of care and the health of our workforce. The collaborative environment in which we are doing our work with the MLC helps to support our optimism about meeting our goals without having to resort to arbitration.

To keep all the stakeholders informed, we intend to continue to issue quarterly updates as we move forward and we would be happy to come back to this Committee whenever requested. We will continue to be transparent with the Municipal Labor Committee, the City Council and the public in our approach to meeting our healthcare cost savings goals.

Thank you again for the opportunity to testify on our progress. At this time, we will take any questions from Committee members.

Table 1

The projected fiscal 9% growth for the HIP HMO rate was a prudent growth factor. The average fiscal year growth rates were 9.4%, 9.0% and 8.9% for the most recent 5, 10 and 15 years respectively

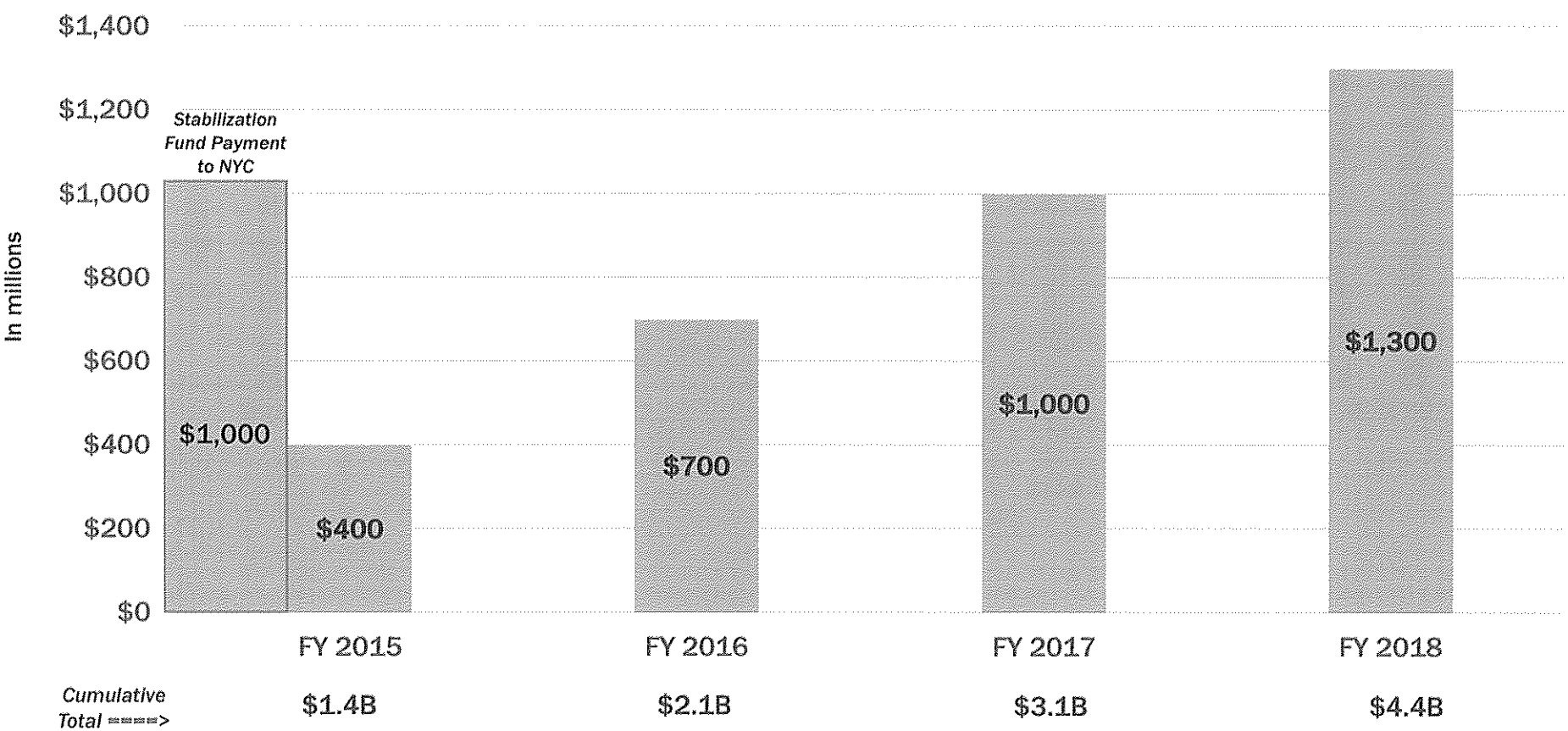


Data Source: OMB

OLR Testimony to New York City Council, April 1, 2015

Table 2

The MLC Health Agreement of May 5th, 2014 saves $4.4 billion:
$3.4 billion in healthcare spending reduction from FY 2015 through FY 2018
$1 billion from the Health Stabilization Fund in FY 2015

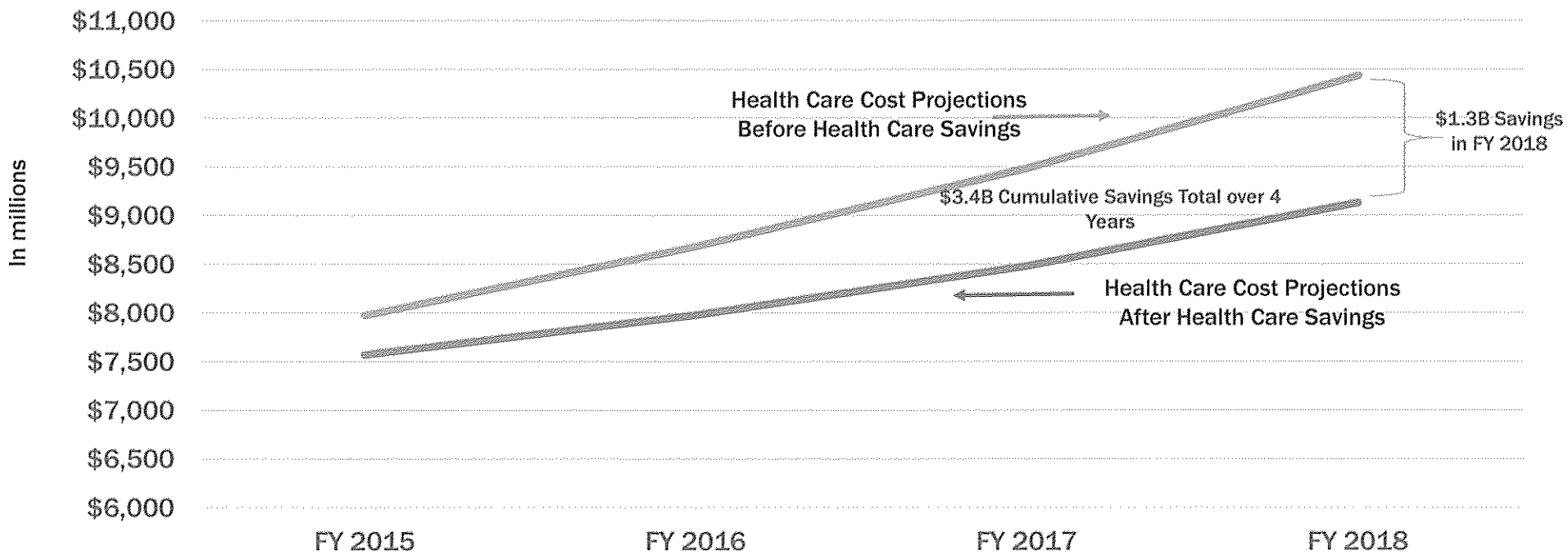


Data Source: MLC Health Agreement, May 5, 2014

OLR Testimony to New York City Council, April 1, 2015

Table 3

Working collaboratively with the Unions, the City will save $3.4 billion in healthcare costs from FY 2015 to FY 2018



Data Source: Jan 2014 Financial Plan projections supplemented with estimates for independent City agencies; savings per MLC Health Agreement of May 5, 2014

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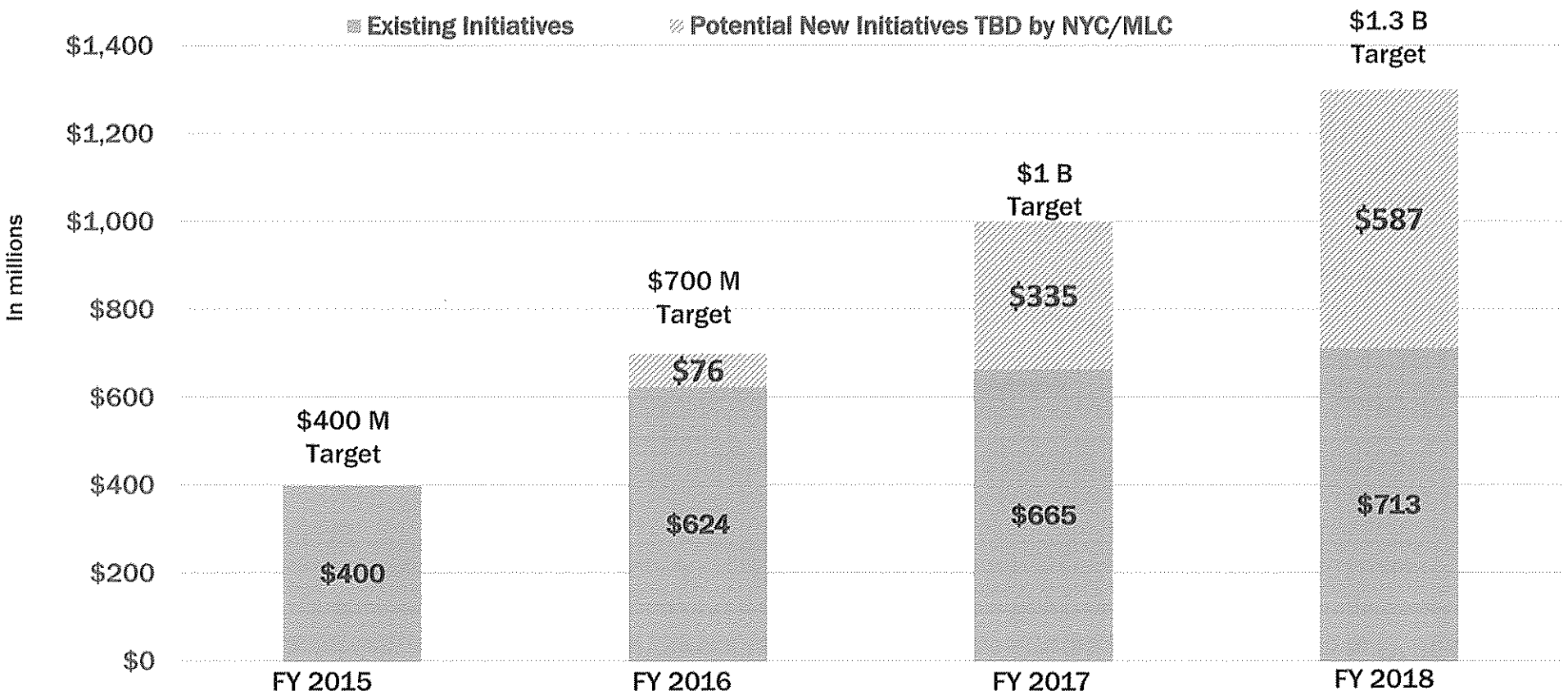
Table 4

Achieving the $3.4 billion savings:
The City and the MLC have already identified initiatives to meet the $400 million savings goal in FY 2015 and have identified close to $2 billion in healthcare savings in FY 2016 through FY 2018

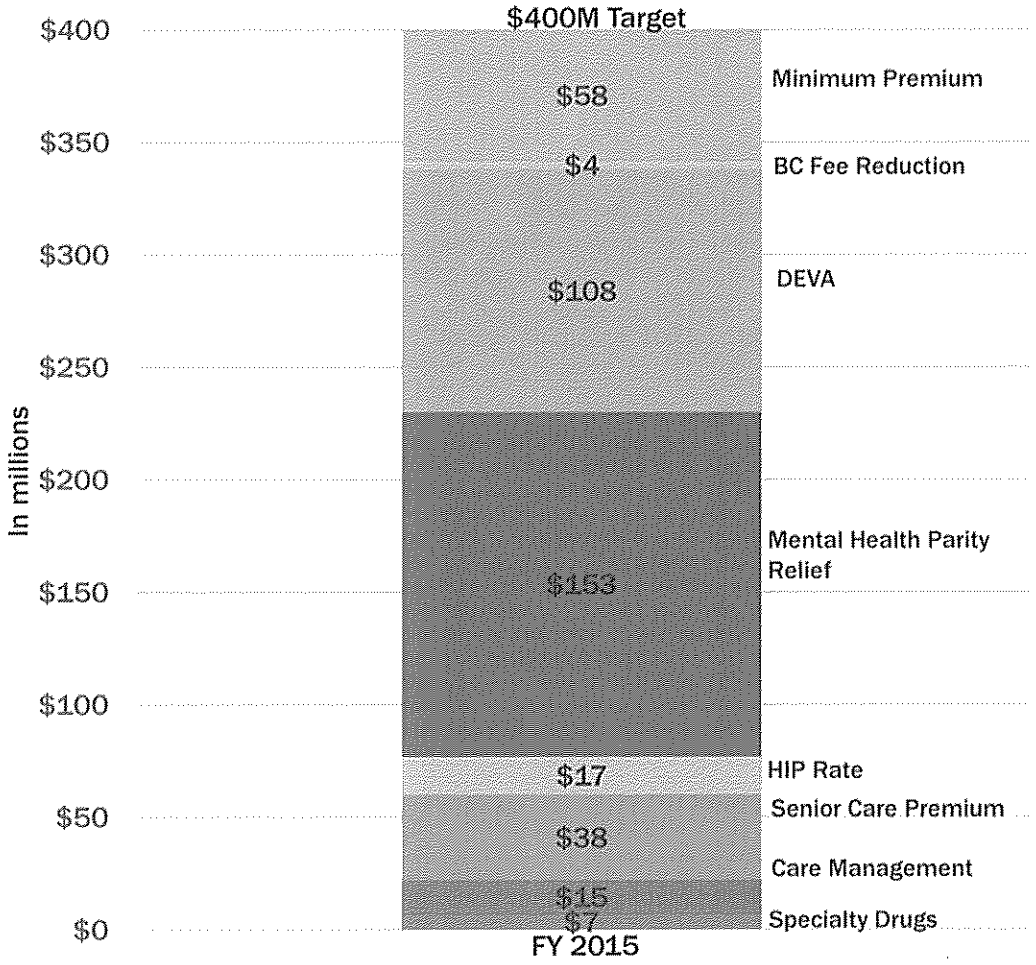


Data Source: OLR Estimates, March 2014

OLR Testimony to New York City Council, April 1, 2015

Table 5

FY 2015 Savings Comprised of Eight Healthcare Savings Initiatives in Four Categories: Audits, Fee Reductions, More Efficient Health Care Delivery and Population Health



Data Source: OLR Estimates, March 2014

- **GHI Minimum Premium Plan:** Conversion from a fully-insured plan to a minimum premium arrangement with lower risk charges, lower administration fees and positive tax implications
- **Blue Cross (BC) Administration Fee:** Reduction in carrier's administration fee for hospital coverage
- **DEVA:** Audit of dependent eligibility for coverage and associated savings from conversion of family to individual health contracts
- **Mental Health Parity Relief:** Union agreement to lower payment to stabilization fund resulting from mental health parity arbitration decisions
- **HIP Rate:** Lower rate increase of 2.89% (vs. 9% budgeted)
- **Senior Care Premium:** Lower rate increase of 0.32% (vs. 8% budgeted)
- **Care Management:** Lower health costs from enhanced care coordination – more timely and comprehensive review of hospital admissions, advanced case management, and readmission management
- **Specialty Drugs:** Renegotiated savings and cost containment provisions such as utilization management and drug quantity management

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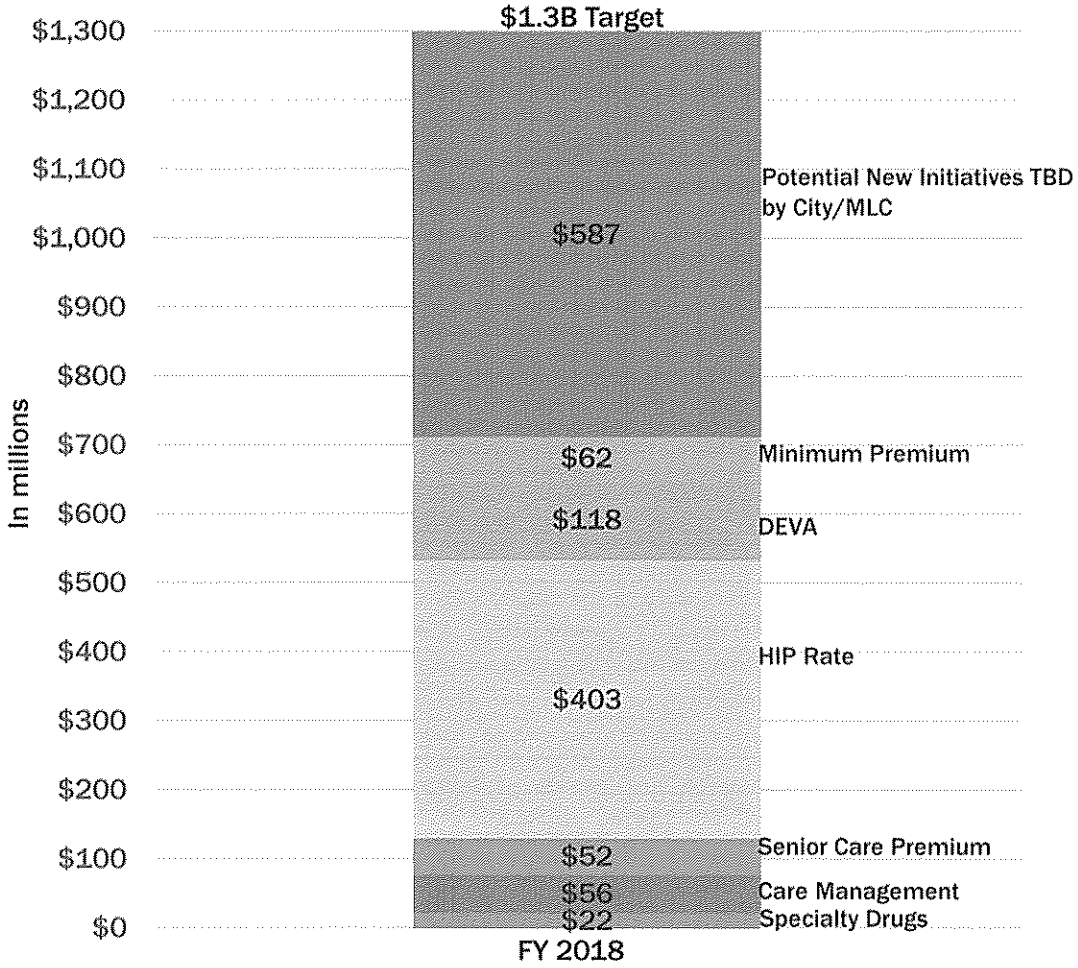
Table 6

The existing savings from FY 2015 is expected to grow to a larger amount in FY 2018. However, a large part of the FY 2018 savings would be from *new initiatives* to be jointly decided by the City and the MLC



Data Source: OLR Estimates, March 2014

- **Potential New Initiatives to be Decided by the City/MLC**
  - Reduce emergency room utilization
  - Wellness programs
  - Opt outs
  - Medicare Advantage programs
  - Self-funding
  - New pre-authorization programs for outpatient procedures
  - Promotion of primary care initiatives
  - New health care delivery models such as ACOs
  - Other

- **GHI Minimum Premium Plan:** Conversion from a fully-insured plan to a minimum premium arrangement with lower risk charges, lower administration fees and positive tax implications

- **DEVA:** Audit of dependent eligibility for coverage and associated savings from conversion of family to individual health contracts

- **HIP Rate:** Lower rate increase

- **Senior Care Premium:** Lower rate increase

- **Care Management:** Lower health costs from enhanced care coordination – more timely and comprehensive review of hospital admissions, advanced case management, and readmission management

- **Specialty Drugs:** Renegotiated savings and cost containment provisions such as utilization management and drug quantity management

Statement of

Professor Sherry Glied
Dean, NYU's Robert F. Wagner School of Public Service and
Former Assistant Secretary for Planning and Evaluation,
U.S. Department of Health and Human Services (HHS)

to the

The Committees on Finance and Civil Service & Labor of the New York City Council
April 1, 2015

Thank you Chair Miller, Chair Ferreras and committee members for inviting me to speak. As the Council Member said, I'm a health care economist and I've studied and published papers on health care cost growth. Today, I'd like to give you a general overview of the processes generating health care cost growth, starting from the global level and moving down to the situation of an individual health plan.

Across all high income countries, annual health care cost growth has routinely outpaced annual economic growth since data began to be collected around 1940. While the cost of healthcare in the United States is far higher than in most other countries, the rate of change in these costs over time in the United States has not been exceptional. This similarity in the rate of cost growth across countries with greatly different health care systems has led most economists to conclude that the primary driver of cost growth across countries and over time must be a force that affects all countries at once – the development and diffusion of new technologies.

Ordinarily, we think of technological development as reducing costs. For example, the development of new, effective treatments for people who have heart attacks led to a big expansion in the markets for bypass surgery, angioplasty, and pharmaceutical therapies. The introduction of these treatments led to a near quadrupling of constant dollar spending on heart attack and heart disease patients over a 20 year period – and also to improvements in life expectancy and quality of life for those with this condition. There are countless other examples.

Over the most recent 5 years, areas closely tied to technology – drug spending and investment – have experienced the slowest growth in spending. But more recent evidence suggests that the trend in these areas is changing, with particularly rapid growth in 2014 in pharmaceutical spending.

Looking within a country over time, economic conditions can lead to fluctuations around that technology-driven trend line. Economic conditions matter for several reasons. First, most health plans require employees to pay premiums. During recessions, when families face financial stress, some will opt to drop coverage altogether, reducing employer costs and total health spending. Second, most health plans require enrollees to pay a share of their expenses as a deductible, co-pay, or coinsurance at the time of use. In tough economic times, those payments bite more, and lead to larger reductions in the use of services, which, in turn, reduce health care spending. Third, some people will reduce their use of elective services because they are afraid to miss time from work in an economic environment when layoffs are more frequent and sick pay may not be available. Finally, in poor economic times, public programs often reduce – or freeze – provider payment levels, which can lead to lower prices for private payers as well. These patterns, driven by overall financial conditions, operate at the level of the national or local economy. Since 2008, as the great recession has hit countries around the world, average health care cost growth per capita in the high income OECD countries has been much slower than historic norms – between 2008 and 2012, it averaged just 2.8 percent and growth in the US was just slightly above that figure.

Local healthcare costs can also be affected by changes in local healthcare market conditions. A growing body of evidence suggests that reduced competition among providers can drive up the prices paid by private health insurance plans. Conversely, many analysts hope that health care reforms that improve integration and coordination of care will lead to lower costs. New York City has seen a recent and continuing wave of hospital consolidations, and also rapid growth in accountable care organizations and other efforts at integrations. These developments affect costs at all private insurance plans in a given market.

At the level of a specific health plan, there are a number of well-understood steps that can be taken to reduce employer costs. One is to increase the employee share of premium payments. Raising the employee share mechanically reduces employer payments by diverting them to employees. In addition, a higher employee share leads some employees to choose to go without healthcare coverage. In some cases, people forego employer coverage for lower cost coverage through a spouse's plan or Medicaid.

A second cost control practice is to raise cost-sharing. Paying a larger share of each health care bill leads enrollees to be more judicious about using care. There's a lot of evidence showing that such reductions in utilization can be quite large and that for all but the lowest income families, cost-sharing induced reductions in use do not lead to deteriorations in health status. Over time, this basic strategy of raising cost-sharing has been refined to incorporate models where cost-sharing is kept low for drugs and services that improve and maintain health and raised for more elective drugs and services (value-based insurance designs), models that combine cost-sharing with tax-sheltered savings plans (health savings accounts), and models that give patients choices over providers with higher or lower cost-sharing, a strategy that Calpers has used in California (tiered networks).

A third strategy for reducing costs is to limit and control the network of providers that is available to patients. By keeping the network narrow, insurers can select providers who score better on measures of quality and cost. They can offer these providers a guaranteed volume of business and negotiate lower rates with them. Insurers can also use a variety of reimbursement and utilization control techniques to encourage lower cost practice patterns.

Finally, there is a range of cost-reduction strategies that involve wellness, health promotion, and case management of high cost cases. The goal of these strategies is to improve the underlying health of the population and thus reduce their subsequent health care costs. I would have to say that the evidence of their effectiveness is mixed.

As you think about strategies for reducing health care costs for NYC employees, it's important to focus on the strategies that work at the level of the health plan. The City has no control at all over the global development and dissemination of new healthcare technologies. It doesn't have much control over the timing of recessions, which can also affect health cost growth. New York City government employees account for only about 10 percent of the City workforce and less than 5 percent of the population, so it's difficult for the City to drive change for the entire local health care system. Over the recent past, these global, national, and local factors have reduced the rate of healthcare spending growth for New York City insurance plans, but it is unlikely they will persist indefinitely.

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TESTIMONY BEFORE THE NEW YORK CITY COUNCIL COMMITTEE ON FINANCE

Testimony by Maria Doulis, Director of City Studies
Citizens Budget Commission
April 1, 2015

Good morning. I am Maria Doulis, the Director of City Studies at the Citizens Budget Commission (CBC). CBC is a nonpartisan, nonprofit civic organization that serves as an independent fiscal watchdog of New York State and New York City governments. Thank you for the opportunity to testify today on New York City's recent health savings agreement.

Before addressing the agreement, I want to note why this is an important issue. As CBC has reported, the cost of the City's health insurance plan has grown rapidly in the last decade. Since fiscal year 2005 costs doubled from $2.6 billion to $5.3 billion in fiscal year 2015 to comprise 6.7 percent of the 2015 budget—more than what the City pays for the police department.

CBC called for negotiating changes to health insurance as part of collective bargaining and was pleased when Mayor Bill de Blasio announced a health savings agreement with the first contract settlement. The City and the Municipal Labor Committee (MLC) agreed to save $3.4 billion between fiscal year 2015 and 2018, with savings to recur in fiscal year 2019 and thereafter. The agreement included annual targets of $400 million in fiscal year 2015, $700 million in fiscal year 2016, $1.0 billion in fiscal year 2017, and $1.3 billion in fiscal year 2018. An independent actuary would be selected to verify the potential savings and an arbitrator would have the authority to impose measures in the event the parties could not agree.

This appeared to be a serious effort to reconsider the City's health insurance arrangements. In June 2014, CBC President Carol Kellermann wrote to Labor Commissioner Bob Linn to suggest guidelines for identifying initiatives and quantifying savings.[1] The two most important were:

1. **Initiatives should "bend the cost curve" and achieve recurring savings for City taxpayers.** Some ways to do this include establishing premium-sharing with employees and retirees, reducing per enrollee utilization of services, better managing chronic conditions, or lowering provider payments, which can be achieved through lower fees for service, higher deductibles, or higher copayments.

[1] Carol Kellermann, President, Citizens Budget Commission, Letter to Robert Linn, Commissioner of Labor Relations, City of New York (June 9, 2014), www.cbcny.org/sites/default/files/LETTER_06062014.pdf.

2. **Savings should be counted clearly and honestly.** Lower national and regional health care inflation, temporary premium rate "freezes," and unusually low premium increases should not be credited as savings gained under the agreement.

In response, Commissioner Linn affirmed the City's intention "to find real, permanent savings and fundamentally bend the curve when it comes to rapidly increasing health care costs"; however, he cited initiatives under consideration that would offer only one-time or temporary savings, such as premium rate caps.[2] In addition, he stated that all savings will be calculated relative to financial plan projections rather than actual results of specific initiatives—thereby divorcing any savings claimed from changes in the benefit structure of the health insurance program.[3]

To date, there has been no public report of savings attributable to specific initiatives. Nevertheless, the November modification gave credit to the MLC agreement for $1.3 billion in savings ($55 million in fiscal year 2015, $377 million in fiscal year 2016, $414 million in fiscal year 2017, and $454 million in fiscal year 2018). The savings are from lower than anticipated premium increases for employee and retiree health insurance plans. Consistent with past trends, the financial plan projected health insurance spending to increase at an annual rate of 9 percent; but, the City's actual rate increase for fiscal year 2016 will be 2.89 percent.

As a result, savings that would have normally been reserved for general budget needs—such as funding libraries or park maintenance—and are attributable to a national slowdown in health care costs, are now being credited to the health savings agreement.

CBC estimates that if they repeat this process in future years—claiming savings for low rate increases against a 9 percent projected growth rate—the cumulative impact would be another $1.2 billion. Thus total savings attributed to the MLC agreement could equal $2.5 billion of the $3.4 billion cumulative target- without any affirmative actions to improve the delivery of health care. And, those savings would not be available for other funding priorities.

Commissioner Bob Linn, his team, and labor leaders deserve credit for agreeing to work collaboratively to modernize the City's health insurance plan. The Commissioner's December 2014 status report describes exploring initiatives, such as reducing emergency room utilization and improving chronic disease management, which can improve health outcomes for the City's workforce and save money for the City's taxpayers. These initiatives are worth pursuing and should be the basis for meeting the savings targets established in the health agreement.

Thank you.

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[2] Robert W. Linn, Commissioner of Labor Relations, City of New York, Letter to Carol Kellermann, President, Citizens Budget Commission (June 9, 2014), www.cbcny.org/sites/default/files/RESONSE_06102014.pdf.

[3] Carol Kellermann, "Statement on Commissioner Linn's Response to CBC Letter on NYC Health Agreement with the Municipal Labor Committee" (June 10, 2014), www.cbcny.org/sites/default/files/STATEMENT_06102014.pdf.

OFFICE OF LABOR RELATIONS

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ROBERT W. LINN
Commissioner

June 9, 2014

Carol Kellermann, President
Citizens Budget Commission
Two Penn Plaza, Fifth Floor
New York, NY 10121

Dear Carol,

Thank you for your letter last week regarding the City's labor settlement and health savings agreement with the Municipal Labor Committee (MLC). As always, we appreciate the CBC's input on this and all issues impacting the City's fiscal health.

I agree with your assessment that the UFT contract is innovative, reasonable, and affordable; that it provides for much needed financial predictability; and that the MLC health care agreement has the potential to achieve significant reforms and taxpayer savings.

The labor agreement also underscores the "reset" in labor-management relations that has occurred between the City and its unions, demonstrating that the administration and public sector labor union leadership can work together in a respectful and professional way to resolve complex and critical problems in a mutually beneficial manner.

As a result, we've reached agreements on issues that many thought to be impossible to solve, and created the means to achieve fundamental and substantial health savings in a system that has not been significantly altered since the 1980's.

The City's agreement with the MLC specifies health care savings targets for each of the fiscal years between 2015 and 2018: respectively, $400 million, $700 million, $1 billion and $1.3 billion. The agreement also includes a dispute resolution clause that guarantees the savings; if the parties cannot meet the specified dollar target goals for a fiscal year, the parties have agreed to meet with the Arbitrator, who has the authority to enforce the savings.

It is important to note that the City has not assumed that cost savings will necessarily be realized through premium cost sharing with employees. The City will first work to find real, permanent savings and fundamentally bend the curve when it comes to rapidly-increasing health care costs.

While the agreement does not define savings as reducing provider payment levels or reducing particular services, it states that the City can consider meeting annual and four-year cumulative savings through a variety of initiatives including: a minimum premium plan (a funding arrangement that allows the City to save a portion of the premium tax); self-insurance (as opposed to a fully insured plan, the City would pay claims out of its own pocket as the claims are incurred); dependent eligibility verification audits; capping of the HIP HMO rate; capping of the Senior Care rate; the equalization formula (collective bargaining agreements require that the City pay the HIP HMO rate for all employees, regardless of which health plan they choose); marketing plans (competitive bidding of contracts); moving retirees to Medicare Advantage (a health plan that contracts with Medicare to provide Part A and B benefits); and more effective delivery of health care. It is worth noting that prescription drugs are not solely a union welfare item; the PICA program (the cost of which is borne solely by the City), would be a part of centralized drug purchasing.

Specifically, our objective is to save money relative to the projected costs in the Financial Plan. The projections in the Financial Plan will form the basis for how the savings will be calculated.

As we implement these cost savings, we will continue to define the appropriate metrics to allow us to measure savings for each program against the baseline costs assumed in the Financial Plan. We will track these metrics quarterly in order to calculate and document savings by program. We are in the process of defining and developing the initial cost savings programs and associated metrics that will be in place for fiscal year 2015, along with the reporting tools for calculating and documenting savings. We envision that the quarterly savings report will be publicly available.

We also are in agreement that dependent eligibility audits should be credited as savings towards the specific health care dollar savings targets. We are implementing ongoing dependent verification audits, and agree that savings should be calculated with a baseline number of people covered and that increases or decreases in covered lives should not affect the calculation of savings. For exactly this reason, we will be using metrics that track costs on a per capita basis.

Additionally, the agreement with the MLC states that the City can consider meeting annual and four-year cumulative savings through the adjustment of the equalization formula.

Thank you again for your comments. We believe that through collaborative and respectful labor management relations, we will achieve fair and reasonable solutions to problems that have been left unresolved for too many years – and we appreciate the CBC's continued input in the process.

Sincerely,

Robert W. Linn

cc: Dean Fuleihan
Harry Nespoli

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June 6, 2014

Robert Linn, Commissioner
Office of Labor Relations
40 Rector Street
New York, NY 10006-1705

Dear Bob,

I am writing on behalf of the Citizens Budget Commission to congratulate you on the ratification of the United Federation of Teachers (UFT) contract you were instrumental in negotiating and to offer input on the effective implementation of the accompanying agreement with the Municipal Labor Committee (MLC) relating to health insurance program savings.

The UFT contract is innovative, covering nine years and providing much needed predictability for the City's Financial Plan. It presents a seven-year pattern for wage settlements with other unions that is reasonable and affordable. Moreover, the MLC agreement for health insurance savings has the potential to achieve significant reforms and taxpayer savings.

At our May 30, 2014 meeting you and Dean Fuleihan said suggestions from the CBC about achieving health care savings would be welcome. Accordingly, we offer the following:

1. As a first step, as specified in the agreement with the MLC, an objective system for measuring savings should be established. The basic principle for defining qualifying savings should be that ***they are recurring and of a nature that truly "bends the curve" in health care costs by making the system operate more efficiently.*** This means savings that lead directly to reductions in per person or per family premium costs. As you know CBC believes the surest and fairest way to realize such savings is premium cost sharing with employees. These savings are easily identified, predictable, and create incentives for employees to seek additional cost containment measures.

2. Absent cost sharing, measures that lower premiums fall into two categories – those that lower per enrollee utilization of particular services or procedures, and those that lower per service payments to providers. Lower provider payments can be based on lower fees per service or higher deductibles or copayments for services.

3. Therefore, to be considered a valid savings measure under the MLC agreement, reform should be associated with specific changes in the plan

benefit structure that either reduce provider payment levels for, or reduce utilization of, a particular service. The calculation of the savings should be rooted in data from the plans on the previous payment amounts per service and utilization rates, the preceding trends in payment amounts and utilization rates which provide a basis for reasonable baseline projections, and actual reductions from those trends in fiscal years 2015-2018 which provide a basis for calculating the savings from the baseline projections. Data relating to the historical pattern and data on actual results should be tracked and made publicly available each month or quarter. An illustration of an appropriate methodology for calculating savings for a hypothetical centralized radiation service initiative is attached to this letter.

4. Because it will not be possible to know the amount of savings from initiatives until well after the end of a fiscal year (because actual payments and utilization data from the plans will be available only with one or more months' lag), there should be advance agreement on how any shortfall in savings will be offset. The City should have a reliable mechanism for recouping amounts of planned savings not actually achieved during a fiscal year.

5. Savings should be based on an agreed upon baseline number of people covered. Increases or decreases in covered lives should not affect the calculation of savings. That is, policy decisions such as increases or decreases in headcount and demographic trends such as increased numbers of covered retirees should not affect the baseline for calculating savings.

6. Reductions in the number of people covered due to eligibility audits are a distinctive type of savings. Because the MLC has grieved implementation of reductions in the rolls from a current audit, the most practical course may be to credit savings related to these actions toward the targets in exchange for union cooperation in eliminating the ineligible enrollees. However, an agreement should be reached that assures there will be regular audits in the future as a matter of managerial discretion.

7. A significant source of potential savings may be possible through changing the status or eligibility of retirees, for example, by moving some or all from City plans to those available on the New York State Health Exchange with federal subsidies. Such options should be studied as part of the joint efforts under the MLC agreement.

8. National and regional trends in health care inflation unrelated to the initiatives launched as a part of this joint effort should not affect the calculation of savings. Lower inflation than anticipated in the City's Financial Plan, absent a clear causal connection to the initiatives identified as part of the MLC agreement, should not be credited towards the savings target (nor should higher than anticipated rates be a basis for a deduction).

9. Temporary "freezes" or low premium rate increases not supported by specific benefit structure changes should not be credited as savings. Past experience shows that such measures are merely deferrals of payments likely to be subsequently offset by future rate increases necessary to replace reduced reserves. An example of such artificial savings are those claimed by Mayor Rudolph Giuliani and the MLC from a three-year rate freeze by HIP during fiscal years 1996-1998; it was followed by rate increases to make up for lost reserves.

10. Additional funding taken from the Health Insurance Stabilization Fund beyond the $1 billion already agreed upon should not count as savings. It does nothing to make the delivery of health care more efficient and is not recurrent.

11. Savings from centralized purchase of prescription drugs not offset by reductions in related union welfare fund contributions should not be counted as savings, since the union welfare funds, not City taxpayers, will benefit from those savings under the MLC agreement.

This list is not meant to be exhaustive. ***The policy underlying all calculations of savings under the agreement should be that only specific measures that make health care delivery more efficient will be credited toward the savings goal.***

We hope you find these suggestions useful. CBC staff would be glad to contribute toward effective implementation of the MLC agreement. Once again, congratulations on the ratification of a significant labor agreement that has great potential for achieving substantial health care savings.

Sincerely,

Carol Kellermann
President

cc: Dean Fuleihan
Harry Nespoli

Attachment

Illustration of Savings Calculation Using a Hypothetical Program to Centralize Radiation Services

Baseline assumption is 1,000,000 enrollees. Fiscal year 2014 average payment per service is $100 and average utilization of service is 20 per 1,000 enrollees. Historical trend in payment per service is an annual increase of 3.0 percent and in utilization per 1,000 enrollees is an annual increase of 5.0 percent. Actual experience after implementation of the program of centralized services is:

	FY2015	FY2016	FY2017	FY2018
Change in average payment	0%	1%	1%	2%
Change in utilization	0%	2%	2%	2%

Calculation of Savings

	FY2014	FY2015	FY2016	FY2017	FY2018
Baseline	$2,000,000	$2,163,000	$2,339,285	$2,529,936	$2,736,126
Actual	2,000,000	2,000,000	2,060,400	2,122,624	2,208,378
Savings		163,000	278,885	407,312	527,748

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Name: Robert W Linn

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I represent: Office of Labor Relations

Address: 40 Rector Street 4th floor NYC

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