CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

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

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HELD AT: Committee Room - City Hall

B E F O R E:
I. DANEEK MILLER
Chairperson
JULISSA FERRERAS
Co-Chairperson

COUNCIL MEMBERS:
Elizabeth S. Crowley
Daniel Dromm
Costa G. Constantinides
Robert E. Cornegy, Jr.
Ydanis A. Rodriguez
James G. Van Bramer
Vanessa L. Gibson
Laurie A. Cumbo
Corey D. Johnson
Mark Levine
Helen K. Rosenthal
Vincent M. Ignizio
Speaker Melissa Mark-Viverito

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

Robert Linn
Commissioner
Mayor's Office of Labor Relations

Claire Levitt
Deputy Commissioner
Mayor's Office of Labor Relations

Ken Gardiner
Associate Director
Office of Management and Budget

Maria Doulis
Director
City Studies for Citizens Budget Commission

Dr. Sherry Glied
Dean
Wagner School NYU

CHAIRPERSON MILLER: Good morning ladies and gentlemen; I'm Council Member I. Daneek Miller, Chair of Civil Service and Labor and before we get started with this morning's hearing we wanna do a little housekeeping, take a vote.

On Monday, the Committee on Civil Service and Labor heard the Resolution 0553-A, calling upon the United States Congress to pass and the President to sign the James Zadroga 9/11 Health and Compensation Reauthorization Act. At some point during today's hearing, which is now, and we have reached quorum and we will be asking the members to briefly pause this discussion on Health Care Savings to vote on this important resolution regarding the Federal Government's continued duty to care for those injured and/or ill because of 9/11, Ground Zero immediately after September 11th. So we can do so now because we have reached quorum. [background comments] Please call the roll.

COMMITTEE CLERK: Kevin Penn, Committee Clerk, roll call in the Committee on Civil Service and Labor, Resolution 0533-A. Council Member Miller.

CHAIRPERSON MILLER: I vote aye.

COMMITTEE CLERK: Crowley. Dromm.

COUNCIL MEMBER DROMM: I vote aye.

COMMITTEE CLERK: Constantinides.

COUNCIL MEMBER CONSTANTINIDES: Aye.

COMMITTEE CLERK: Cornegy. By a vote of 3 in the affirmative, 0 in the negative; no abstentions, the item has been adopted.

[pause]

SERGEANT AT ARMS: Quiet please.

CO-CHAIRPERSON FERRERAS: Good morning and welcome to today's Oversight Hearing on the health care savings under the recent collective bargaining agreements. I am Julissa Ferreras and I am the Chair of the Finance Committee. This hearing is being jointly held with the Committee on Civil Service and Labor, Chaired by Council Member Daneek Miller. I wanna thank everyone for joining us today. We've been joined by Council Member Dromm, Constantinides and Minority Leader Ignizio.

Today we will examine the Health Care Savings plan put forth by the Administration and the Municipal Labor Committee pursuant to a May 2014 agreement between the two parties which created a process to achieve $3.4 billion in savings on insurance costs over a four-year period.

Before we begin, I'd like to thank the staff of the Finance Division for working diligently to prepare for this hearing, specifically I'd like to thank our Chief Economist, Dr. Ray Majewski; my Chief Counsel, Tanisha Edwards; Finance Analyst, Chris Eshleman and Assistant Counsel, Rebecca Chasan.

We have been joined today by Speaker Melissa Mark-Viverito; she has been very interested in this issue and before I continue my opening statement I will pass the mic to the Speaker to say a few words.

SPEAKER MARK-VIVERITO: Thank you, Chair Ferreras and Chair Miller for holding a hearing on such an important issue.

As the Finance Chair mentioned, as part of a May 2014 agreement between the City and the Municipal Labor Committee, a process was created to achieve $3.4 billion in savings on insurance costs over a four-year period. According to the Administration, these savings are crucial to help offset new agreements under the collective bargaining pattern that was established in May 2014 with the settlement of the UFT contract.

Under this agreement there is assumed to be $400 million in savings for Fiscal Year 2015, $700 million in savings for Fiscal Year 2016, $1 billion in savings for Fiscal Year 2017 and $1.3 billion in savings for Fiscal Year 2018. These savings, if realized, are crucial. Between Fiscal Year 2004 and Fiscal Year 2014, health care insurance spending for current employees, retirees and their beneficiaries grew at an average annual rate of 8.3 percent. In Fiscal Year 2015, we are expecting to spend about $5.4 billion on this insurance.

While the goal of this agreement is to address the ever increasing cost of health care, details of the agreement are lacking. As of Monday, only two documents about the savings plan have been made publicly available. First is the agreement itself, which is limited to two pages and sets out the basic intentions of the plan in broad strokes. Second, at last year's Executive Budget hearings in May, the Administration promised to provide the Council with quarterly updates on the plan. The first update, which consisted of just three pages, was not released until December. A second update is just being released today and we look forward to

hearing testimony from the Administration about the details contained in the report. As a result of the lack of information known about the savings plan, many questions still remain about how the health care savings will be achieved and how the savings will be measured. How will we know if we have actually achieved any savings over time? What is the baseline against which the claimed savings will be measured? Will the measurement take into account external factors, such as the health care reform taking place on the national level? And moreover, questions remain about the agreement itself and the process set forth within it. What happens if the health care savings are not achieved; what role will the independent actuaries play and will public employees see a decrease in benefits as a cost-saving method? These are the questions which I hope to receive answers today. I look forward to hearing from the Commissioner, Bob Linn and Deputy Commissioner Claire Levitt of the Mayor's Office of Labor Relations and Associate Director Ken Godiner from the Office of Management and Budget to hear more details on the agreement and the expected savings. So thank you for being here and Chair Ferreras, thank you.

[background comment]

CO-CHAIRPERSON FERRERAS: Thank you Madame Speaker.

As we all know, when Mayor de Blasio took office last year he inherited a collective bargaining crisis. Since 2012 all City employees had been working without a contract and tens of thousands of employees had been working without a contract for even longer than that. In less than a year-and-a-half in office, Mayor de Blasio and his Office of Labor Relations have successfully negotiated contracts with unions representing over 76 percent of the City's workforce; they did so by bringing the unions to the table through a collaborative negotiating process. The efforts should be commended and I'd like to take this opportunity to congratulate them on their success. The wave of contract settlements was initiated last spring when the City and the United Federation of Teachers reached a collective bargaining agreement, which established a pattern as the basis for settling labor contracts with the rest of the City's union. Following such a pattern, it is projected that the settlement of the collective bargaining agreements will cost the City

$14 billion over the four-year financial plan. To partially offset this cost, in May 2014 the Administration and the Municipal Labor Committee, an umbrella organization representing all of the City's unions, entered into an agreement to achieve $3.4 billion in savings on health care insurance costs over a four-year period. The agreement stated that $400 million must be saved in the first year, $700 million in the second year, a billion in the third year and $1.3 billion in the fourth year.

The Administration and the unions are right to address the issue of ballooning health care costs. Over the last ten or so years health care spending has grown at an average annual rate of 8.3 percent and in Fiscal 2015 alone, the City is projecting to spend $5.4 billion and because health insurance is subject to collective bargaining, the opportunity to take these steps to slow the growth of this spending does not present itself often.

But while the agreement between the City and the unions is significant in its big picture goals and represents a crucial step forward in addressing a serious fiscal issue facing our city's future, the fact of the matter is that there is a

considerable lack of detail known about the savings plan. Formal identifying details of the plan and its progress have been limited to the two-page agreement with the MLC and three-page administrative update from the Office of Labor Relations to the Mayor in December of 2014 and opinions published by the Administration in the press; not a lot for a $3.4 billion plan. This lack of detail is especially troubling since the health care savings plan can be interpreted two ways.

First, it could be interpreted as a PEG with a guarantee; if the agreement was that the City committed itself to a level of spending on health insurance that is below the February 2014 financial plan by a total of $3.4 billion over four years that it is similar to a PEG; however, since PEGs can fail when targets are not reached and nationally the growth of health care spending has been notoriously difficult to control, this PEG has a guarantee of savings, specifically the process outlined in the agreement. The process sets forth that in case where the savings are not reached, the parties must engage in negotiation aided by actuarial assistance in valuing options and arbitration. Under such an

interpretation, so long as the lowered spending targets are reached, regardless of whether those savings were as a result of efforts of the City or the MLC, then the terms of the agreements have been met.

The second way the agreement could be interpreted is as a commitment between the City and the MLC to engage in a collaborative and creative process to find savings in health insurance and to share those savings between the residents of the city and the City employees. Under such an interpretation, savings that are achieved by factors outside of these parties' control would not be credited towards the saving targets; this interpretation seems consistent with the language of the MOU between the City and the MLC and reflects a desire to share savings that exceed the $3.4 billion goal.

Each of these interpretations is legitimate; however, the two readings make different demands concerning how we measure and how we attribute health care savings. The first demands that certain units of appropriate in the budget be limited to certain levels of certain years. It also

requires that the savings be ongoing and does not consider where the savings come from. The second reading looks for savings from a process of engagement between the MLC and the City. With this reading, the understanding is that savings that are part of the national patter or that are a result of actions taken prior to the start of the agreement are great, but we should not be counting on them.

As you can see, two different and very plausible interpretations can be read from the agreement. To help us understand this agreement and the complex subject of health insurance for the City employees, retirees and their dependents, we look forward to hearing today from Bob Linn, Commissioner of the Mayor's Office of Labor Relations. Commissioner Linn will be joined by Deputy Commissioner Claire Levitt, who has joined the OLR specifically to bring her health insurance expertise to the City. To help us understand the national dimensions of health insurance costs, we will be joined by Dr. Sherry Glied, a distinguished health care economist and Dean of the Wagner School at New York University. In addition, we will hear from Maria Doulis, Director of the City Studies at the

Citizen Budget Commission, which monitors the City's budget and has shown great interest in this issue.

Before we hear from these witnesses I will now turn the mic over to Chair of the Committee on Civil Service and Labor, Council Member Miller to make his statement. Thank you, Council Member.

[background comments]

CHAIRPERSON MILLER: Thank you. Good morning again and once again, I'm Council Member I. Daneek Miller, Chair of the Committee on Civil Service and Labor. Thank you to Chair Ferreras for holding this important hearing, even as Finance Committee is already extremely busy with the budget and let me say that your office and this committee has done a tremendous job in preparing and I'd like to thank Speaker Mark-Viverito for being here and the support that she has given here as well.

Again, I'm sorry, but with just a brief housekeeping and I'd like to acknowledge members Cornegy, Rodriguez, Crowley, Gibson and Rosenthal, as well as Dromm and Constantinides, who we already acknowledged, but we'd like to -- again, the vote was held open for Monday's 0553-A Resolution, extension

of the Zadroga Act and would love for you to now vote on that… [crosstalk]

COMMITTEE CLERK: Crowley.

COUNCIL MEMBER CROWLEY: I vote aye.

COMMITTEE CLERK: Cornegy.

COUNCIL MEMBER CORNEGY: I vote aye.

COMMITTEE CLERK: Final vote in the Committee on Civil Service and Labor, 5 in the affirmative, 0 in the negative; no abstentions.

CHAIRPERSON MILLER: Okay. Now returning to the topic at hand, I am interested to learn more about the health care agreement between the de Blasio Administration and our city's organized labor workforce. We're looking at a large target of $3.4 billion in health care savings during these next four years. A target that was created at the City's collective bargaining agreements came into focus; as someone who has been a part of both sides, of government and on the union side, let me tell you with confidence that the collective bargaining process is most sacred; it has served to benefit millions of working people throughout our nation and continues to be a value to today. There are an established set of norms in the process and when

properly observed, these norms serve to promote both fair compensation and fiscal responsibility. In this case we see the collective bargaining process brought about shared sacrifice between the City and its workforce, represented by their unions in order for a $14 billion increase in wages meant to keep up with the rising costs, such as rent and transportation and other necessities. Municipal unions agreed to partner with the City to reduce health care costs by $3.4 billion. I expect that all sides will be able to fulfill their terms of this agreement. With that in mind, however, I am looking forward to know what we have been told, what will be available, detailed presentation from the Mayor's Office of Labor Relations on this topic. I am also looking forward to hearing from experts in this area and other parties of this agreement.

Before we begin the hearing, I'd like to acknowledge Committee Counsel Matt Carlin, Policy Analyst Garfor Zoloff [sp?] and of course, my Legislative Director, Mr. Ali Rasoulinejad.

And with that I pass it back to Madame Chair.

CO-CHAIRPERSON FERRERAS: Thank you, Chair Miller.

We've made calls to hopefully stop the construction and… [background comment] [laughter] but perhaps someone from the Mayor's Office can call. [background comment] [laughter] And I'm hoping this hearing is full of detail, 'cause it's the Speaker's birthday, so I'm sure she would love [laughter, cheers] to have this as a gift. Yes. We will… [background comments] no days off. So I'm gonna ask my committee counsel to swear you in and then we will begin your testimony.

COMMITTEE COUNSEL: Do you affirm that your testimony will be truthful to the best of your knowledge, information and belief? [background comment] Okay, you may proceed.

ROBERT LINN: Thank you. Make sure that I can be heard over the sound. [background comments] Okay.

Good morning and happy birthday, Speaker Mark-Viverito, Chair Ferreras, Chair Miller and members of the Finance and Civil Service and Labor Committees. Thank you very much for the opportunity testify today; I'm joined by Claire Levitt, who's

already been mentioned, who is the Deputy Commissioner for Health Care Cost Management; I will describe a little bit more about her role in the office a little later on; Ken Gardiner, Associate Director of Office of Management and Budget, who's intimately involved in all of the labor negotiations that the City conducts.

There's been a lot of confusion about the health care savings, so I truly welcome the opportunity to be present this information to you.

And I want to point out that the nature of collective bargaining, of which I thoroughly subscribe, is not to discuss agreements publicly until agreements are made and approved by the membership. This is so much more complicated when there are 144 unions, like we have in New York City and they all are represented by the Municipal Labor Committee.

I've often said that the test of how good collective bargaining is is how little you hear about it publicly and the more you hear publicly about collective bargaining I think the less fruitful the negotiations are. So I think it's a tribute to our conversations that we've been having with the

workforce that we have privately engaged in discussion, in conversation, in collaborative efforts to find agreements, and I hope you can understand and bear with that approach that the process we've been going through is not to hid from anybody or not to show a lack of transparency; our purpose has been to reach collaborative, good agreements with the workers, have them approved by the leadership and the people that have to approve these agreements and then to bring them to the public after we've done them, and in fact today we are going forward with the first part of our presentation of the $3.4 billion because we're gonna successfully talk about the $400 million that we've achieved for the first year.

So I am gonna take a while to take everyone through this and I hope you'll bear with me, but I know that there is tremendous interest exactly in what we're doing and how we're doing it and so we've really prepared today to discuss at length just what we're doing and how and why.

So as you know, the municipal unions embarked last year on an unprecedented four-year agreement to achieve $3.4 billion guaranteed dollars of cost savings and to bend the cost curve in doing

so, and I'm going to present graphs at the end and tables at the end; it's gonna talk a little bit about why I believe in fact we have begun to accomplish this, why we are accomplishing this and why we will accomplish the full amount, if not exceed the amount we're talking about.

The result is we've changed the dialogue from one of confrontation and deadlock to collaboration and problem-solving. I take great pride that we have done that, that we've reached all the settlements that we've reached and we've done it in a way that is not all over the front pages of the paper, but is between the parties, reaching deals and reaching very successful membership ratification of the agreements we reached.

So we're here today to report on the successful progress of the Municipal Labor Committee and the City of meeting the goals of the first three quarters of 2015 and our plans for the future. And in fact we just earlier this morning released our latest report where we do detail the $400 million we're saving in Fiscal 2015 and I'm gonna discuss that now and I'll discuss it again over several

iterations, so everyone is clear on just what we're talking about.

So let me start by putting the labor management efforts of the de Blasio Administration in perspective. When Mayor de Blasio took office in January 2014, every single contract with municipal workers had expired. As was mentioned, in a little over a year we've achieved settlements with 76 percent of the workforce, both civilian and uniform force workers. The Administration from the very beginning was committed to a respectful and collaborative labor management program to settle the massive collective bargaining failure we inherited in a manner that was both fair to the workers and accepted as fiscally prudent by our fiscal monitors. In fact, all of the agreements we've reached have been ratified by 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 & Poor's stated that with the labor pattern we established last year, and I quote, "the City now has an element of certainty in this financial plan that it lacked in

the past, when labor settlements and associated wage benefit increases were unknown."

As part of the agreement, the Administration committed to solving the intractable health care costs containment impasse that developed in the city for over two decades. Over those 20 years while health care costs skyrocketed and employers all over the country adapted their programs, New York City did little to modernize its programs. City labor agreements required the City and the unions represented by the Municipal Labor Committee to agree on any changes to health care benefits plans. Collective bargaining strife precluded reaching agreement over the challenge of rising health care costs, even as it became a standard operating procedure for both public and private sector employers to modernize their benefit programs.

The New York City 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, and I hate to say that I am part of that history; the first time I was here in 1982 I was

involved in those negotiations, when the HIP/HMO was considered the most efficient model for health care delivery rates and it was thought that if we connected the City's contribution to those rates that that would provide cost containment in the health benefit system. And so we provided that the City would commit, would equalize its payment to health insurance to pay the HIP/HMO rate and we then later on agreed that there should be a stabilization reserve fund, and that stabilization reserve fund was also set up in the 80s and was set up under the purpose of deal with the fact that everyone at the time thought that the GHI/PPO, the Preferred Provider Plan, would be more expensive than HIP/HMO and so we put aside a stabilization fund that was funded in collective bargaining that would have extra dollars available so that workers could have a choice of plans and those extra dollars would pay for what we anticipated would be the extra costs for GHI over HIP. What was never anticipated in '84 was that the HIP/HMO rate would become far greater than the rate for the GHI plan and it has remained higher, dramatically higher, since 2001, and under those old agreements the City was obligated to make substantial

annual payments to the stabilization fund and when we came in as part of this administration, the stabilization fund was projected to accumulate $1.7 billion. So a fund that was meant to be available to enhance the payments for the GHI plan in fact created a fund that had $1.7 billion available, but only was available through the mutual agreement of labor and management.

So while over the past 10 years the cost of providing benefits in New York City has doubled and the Affordable Care Act added additional cost, as we know from expanding child coverage to age 26 and other benefits, the attempts by the prior Administration to deal with these costs and to have the workforce sharing cost coverage resulted in arbitration, litigation, court proceedings and the City generally lost those challenges and so we had a $1.7 billion stabilization fund and we had a benefit structure that looked very much like health benefits looked 25 years before.

In 2013, before the de Blasio Administration took office, an attempt by the City to unilaterally, without the union agreement, to go and bid for a new health plan, ended in litigation and

the MLC forced a retraction of the RFP. So this Administration concluded that we would not conclude our collective bargaining without addressing the critical issue of health care cost containment. And in May, under the Mayor's leadership, we entered into the agreement, what has often been referred to as the Linn-Nespoli letter, which is the letter that the Speaker referred to earlier on.

Now let me discuss that letter for a minute. First, a billion dollars of savings, one billion of the 1.7 was released to cover the cost of collective bargaining. So one should not forget that part of the agreement was a billion dollars. Now to put that in perspective, if City workers were to contribute one percent to health care costs, one percent of their pay to health care costs, that's $200 million. So the billion represented five times as much, so there was a huge contribution to collective bargaining and to the collective bargaining costs by the agreement that the City could use the billion dollars to help fund collective bargaining, but that was just the beginning of the agreement. We then secured an agreement to have labor and management work together to generate

cumulative savings of at least $3.4 billion over Fiscal Years 2015-2018. Now many have criticized us; why weren't we specific in how we were gonna do it? And it was by design, it was by agreement that we were not going to specify how to do it, because that type of conversation would be -- okay, I want you to pay or no we won't pay or I want you to make this contribution or this payroll deduction; we said no, let's establish dramatic savings, way beyond the numbers that anyone was contemplating, let's establish dramatic savings and let's figure out together how we find those savings, and what I'm about to describe is exactly how we've worked together so far in the very first part, and no one should forget, this is a four-year agreement; we are just nine months into that first year, and so it wouldn't be correct to view that in the first three months, six months we should be able to spell out how the agreement should look; we are working together to find those savings and we're finding those savings and that's what I'm about to describe, but I think people have misunderstood, this is a collective bargaining process where the role is labor and management together to find savings, indeed actually

find savings versus the budget in the financial plan that we had when we started this bargaining.

So we're scheduled to save $3.4 billion, $400 million in the first year, $700 million in the second, a billion in the third and $1.3 billion in the fourth and thereafter, and the $3.4 billion is guaranteed by an arbitration process, so let me talk about that a little bit.

That we have agreed that if we can't through labor/management efforts find these savings, then we have an arbitrator and this arbitrator could come in, either at the end, in the middle; either party can ask the arbitrator to come in and work with us to find those savings, and what I'm proud to report is we have not used the arbitrator so far and it is my hope that we find in excess of $3.4 billion without any arbitration decision. But then you get to the most important part, I think of the agreement, which is beyond all of these savings we provided that there would be gain-sharing of savings if we can go beyond $3.4 billion. And the first $365 million, which is the equivalent of a one percent increase, including the fringe costs associated with it, that the first $365 million above the $3.4 billion would

go to the workforce as a bonus payment, and if there are savings beyond that, it would then be split 50/50. And this innovative approach to sharing savings beyond the 3.4 came not from the City; this was a union proposal and I'm now saying one of the most innovative aspects of this settlement is that the unions said, suppose we can beat $3.4 billion; what are we gonna do with those dollars and we've agreed how those dollars would be used. So again, I'm trying to give the flavor of the bargaining process, that we made a proposal, we said we wanted to save this amount, the $3.4 billion; the unions said we not only will sign onto the process, but we think we can go beyond those numbers and if we do, we want to share additional amounts, and that's what we agreed to.

So the bargaining over identifying the specifics of the savings has been what we've been doing for the last six months and we believe that the process that began, and I can only speak about the chilling first meetings of people looking at each other and having experienced the discussions of years of not reaching agreement on anything, to all of a

sudden having a dialogue over issues of mutual interests.

So I wanna take a moment to recognize the efforts of the MLC unions, their leadership, especially Harry Nespoli, the President of Sanitation Workers and the Chair of the Municipal Labor Committee and there have been two expert advisers, Arthur Pepper of the UFT and Willie Chang of DC 37, they are the co-chairs of the Labor Management Health Insurance Committee. Their leadership and willingness to work with us to achieve our health care saving goals has transformed our vision into this beginning of the reality moving forward, and the groundwork accomplished in less than a year creates a real momentum towards a $3.4 billion health care savings, and I'm going to take you through exactly how we think those dollars are going to work in the minutes to come.

To lead the effort of the City, and Claire was mentioned before, the City created a new position of Deputy Commissioner for Health Care Cost Management, a position that is focused on the issue of managing health care costs and it speaks of how

differently this Administration is approaching to the challenge.

Since the moment Claire arrived; she probably feels it was years ago that she arrived, but from the moment Claire arrived, only six months ago, she has been 100 percent dedicated to making this unique labor agreement successful and I wish to offer my appreciation for all that she has accomplished; she comes from a background of 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 the context of what she describes as the triple aim of simultaneously improving the health of the population, enhancing the patient experience and outcomes and thereby reducing per capita cost of health care. Working within this philosophy to improving care goes hand in hand with generating savings; she's also helped generate labor management contention into cooperation.

So here, after less than a year, I'm pleased to announce that we've reached the $400 million goal for the first year and the current and future savings initiative align with four different

approaches we've adopted. The approaches are that we're going to aggressively attack rates wherever we see them, both the State HIP/HMO rate that drives premium rates and the rates for our insurers and vendors. Second, we're initiating audits and continuing audits of all our programs; the first was a major undertaking to ensure that we are covering only eligible workers. Third, we're looking at changes in the way health care is being delivered to our workforce to improve quality and to make it more efficient. And fourth, we're focusing on improving the health of the workforce, our families and our retirees. All savings are being realized by the City; that includes savings from programs and initiatives that result in lower amount actually paid in services and savings from agreement with the MLC to lower the City's equalization fund payments.

There have been eight specific strategies that have resulted in the $400 million that I'm now reporting and we've released the third quarter report with the detail information that's similar to what I'm now gonna go through. So let me go through the 2015 savings detail.

As you know, the savings are measured against the 2015-2018 budget projections, a quantifiable and logical number to look at. And I think I'll move to Graph 1, just to make this point at this point, because some people have said, why did we use a 9 percent assumption in health care costs as the basis of finding our savings? [background comments] Okay. And so the question is; why did we use 9 percent; was that somehow an inappropriately inflated rate? Because after all, what we're looking at are the savings that we've achieved versus the budget projections; that's how we bargain in this contract, and if you take a look at Graph 1, Table 1, you can see looking back over time health care cost increases are highly volatile, as we all know and that chart shows back to 2000; the health care cost inflation, the trend rate was 6.6 percent, it them moved to 9.1, to then 11.9 and then it tailed off again in 2003 and 2004, and then spiked up again in 2005 and then went down again in 2006, 2007 and 2008. And if you then see the inflation in 2010, 2011 and 2012 you see inflation in double digit -- 11, 11.2; 10. And so there has been a moderation of health care costs in 2013, 2014 and 2015 and hopefully that

will continue. But if anyone suggested that we should look at just 2014 to project our costs going forward, I think every monitor would've said we're crazy; they would've jumped up and down. So we took a look at the long period of time and if you look over 10 years, the cost averaged 9 percent. If you looked over the last five years it averaged 8.9 percent, and if you look at the over 15 years, it was 8.9. So a range between 8.9 and 9.4; certainly the choice of 9 percent… [interpose]

CO-CHAIRPERSON FERRERAS: I'm sorry to interrupt you, but I think that… [crosstalk]

ROBERT LINN: Yes.

CO-CHAIRPERSON FERRERAS: I just wanted to specifically ask about this slide. Would you be able to let us know why the dip of 2014, since it was the lowest in the 14 years, why do you see the dip happen in 2014?

[background comment]

ROBERT LINN: What it's attributed to? You know some say that the Affordable Care Act had an impact; there were -- clearly costs headed down for a year or two; some of the rate increases we're getting now are double-digit again, so whether this is

temporary or long-term, I'm not sure; they did follow a spike that occurred in the years before and so whether or not there was a period of a lull -- but I will let expert advisers to occur that [sic]. We actually -- we did challenge the HIP rate that year and were able to achieve a reduction in the HIP rate which brought down cost. But it seems to me if we are forever in a period of lower inflation for health; we're all much better off for that. It certainly would not have been prudent when we began this administration to not use the same projections the prior administration was using, given when you look back over time, 9 percent seemed like a good rate. So the answer to the question is; the costs are versus the financial plan projections using those health care cost trend assumptions.

And so we then, based on that analysis, said we need to find $400 million of savings and the first thing we did -- and as we look along -- why don't we go to slide… is it three… four, slide four. No, slide five, slide five, because you have a detail in slide five that talks about the various items that we were able to achieve. And so we agreed that in the GHI premium, which covers about 75 percent of the

workforce for medical coverage, we changed from a fully insured program, where the risk was with GHI, to something that we paid -- to a change that's called the Minimum Premium Plan Agreement, and this results in significantly lower risk charges, lower administrative fees and positive tax implications, reducing costs by $58 million. Now I have to say, this was not a brand new idea of this administration, but it required an agreement with the union to move to this approach, so that was able to establish $58 million. So put in perspective, we had an agreement with unions to save the billion dollars; we then had an agreement that we would go to a minimum premium.

On hospital coverage, we negotiated directly with Blue Cross the administrative fees should come down and that represents a $4 million savings.

To ensure that all health premiums reflected an accurate headcount, we went through extensive audit to verify whether all the dependants listed in the City employees and retirees were actually eligible. Now we didn't start that; that was begun by the prior administration, but through a collaborative effort with the unions we've moved

forward and we've identified 14,000 contract conversions that changed family coverage to individual coverage; that's the point, if people are saying that they have a right to family coverage and are covering individuals -- students who are over age 26 or no longer living in the household, if they are no longer married -- all of those types of items need to be identified periodically and the fact that we did go through that process, we believe we're gonna save $108 million from that, and so that is a direct savings versus the health care projections and required the work with the unions to achieve that and we are saving $108 million to do that.

There then was the issue of mental health parody where there was a federal mandate that mental health benefits be equal to medical benefits and the last administration unilaterally concluded that the difference should not be counted in the HIP rate and they agreed that they simply could lower the contribution to the stabilization fund. Well they didn't have the union agreement, the union filed for arbitration in July 2013 and in October 2014 an arbitration panel ruled no, the City could not reduce unilaterally those payments; it had to get an

agreement. So what did we do as part of this? We go that agreement and the unions have agreed that we're not going to make those $153 million payments to the stabilization fund, so we're going to get $153 million out of that issue that the last administration sought to get, was unable to achieve and we achieved through collective bargaining.

To help control costs for hospital admissions, the City has a hospital pre-authorization program in place, since 1992, but it hasn't been updated since 1992. And recognizing that more than 50 percent of the health expenses are incurred by only about 5 percent of the population and that 1 percent of the population is responsible for over 20 percent of the spending, it is common today in most labor and public/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 they provide much needed assistance to employees and families facing significant illness and hardship.

So beginning March 1, the existing pre-authorization program was enhanced to provide a more timely and comprehensive review of hospital

admissions, to provide nurse case managers for all patients and complex, acute and chronic conditions, providing much needed assistance to employees and dependants and retirees with severe medical conditions. This will include patients with cancer, high-risk maternity situations, transplants, HIV and other conditions. In addition, a readmission management program is being implemented to help ensure that patients have services they need when they're discharged from the hospital in order to prevent unnecessary readmissions. These programs are going into effect in late 2015, so the savings in 2015 will be about $15 million, but they grow to about $50 million in the next year.

In addition, this program has not been competitively bid for years and we will agree with the unions that there should be an RFP to allow us new vendors and new approaches and this change that we expect will have a significant impact in bending the heath care cost curve while providing needed support to our employees with extreme medical needs.

Another area of significant focus for health care cost increases has been prescription drugs and although individual union welfare funds

provide the basic health care coverage, and let me just explain that for a minute. The City, for at least 40 years, has provided dollar contributions to union welfare funds; those funds are generally the main provider of prescription drug coverage. Those funds have deductibles, those funds have co-pays; those funds have -- many of them have steerage into generics, as opposed to brand name drugs. But that part of the health care process generally comes through the welfare funds, but the City provides coverage for specialty drugs, like biologics and injectable drugs; this is an area of extraordinary and growing costs and we renegotiated provisions of specialty drug program to deliver substantial savings to the City. In addition, certain cost-management provisions, such as additional pre-authorization and drug quantity management programs were added to enhance the savings.

So the changes that took place in January of 2015 we believe -- some took place in January 2015; others in May -- we believe that will save us $7 million this year and will grow to $19 million next year.

As discussed, this cost of the City's health care contribution for employees and pre Medicare retirees is tied also to rate approved for the HIP/HMO. And we vigorously disputed the rate increases requested by HIP and we were successful in getting HIP to reduce the increase for next to 2.89 percent. A small amount of those savings hit in 2015 and the bulk, about $17 million, which you can see on the table there, and the bulk you'll seeing coming into effect in the year thereafter.

And likewise, senior care premium rate increases for FY 2015 was originally budgeted at 8 percent came in at .32 percent, resulting in a $38 million savings in 2015.

So as you can see from the table over there, all of that adds to a total of $400 million. And that is going to be the foundation for savings going forward. As part of our cost containment efforts we're looking at ways to combat some specific diseases that impact New Yorkers. So the union has invited us to work with them to actively look at diabetes and diabetes management, which affects 29 million people in the U.S. and more than a quarter of them don't even know that they have diabetes. It's

the seventh leading cause of death in the country and we know that many of our employees are living with profound health impact of diabetes and to help address this program we're implementing a case management program that specifically provides special support for patients with diabetes. This program is in the implementation phase; is gonna start July 1, 2016 and we believe will actually save $3 million in FY16, which will be guaranteed as part of our rate discussions in our work with vendors, guaranteed by the vendor.

Finally, we're 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 assist them in learning strategies to prevent onset. Simple lifestyle changes have helped many people prevent the delay and the onset of this disease and we plan to offer worksite programs, as well as online programs to reach the widest number of employees and their families.

And then, as I mentioned before, we are committed to creating a culture of health in our workforce. Unlike many other cities, New York has not implemented any workforce wellness initiatives, so we're looking at piloting a number of programs to encourage fitness. to promote better nutrition, combat obesity, promote smoking cessation and reduce stress for the City workforce. Many of these programs' approaches won't have quantifiable savings if we can specifically measure in the next year or two, but are part of 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 it can have significant cost savings implications.

To support these efforts we're going to be introducing an employee 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 City flu shot program last fall, which provided free flu shots to all City employees and increased access to making the shots available within the worksites, at pharmacies, as well as physician offices. And I might report that I went with Harry Nespoli and Dr. Mary Bassett to a Sanitation garage at 5:30 a.m., where we all got our flu shots as part of this program.

So as I said, there are now gonna be savings beyond 2015, into 2015 and thereafter. And as I noted before, many of the 2015 programs will have a greater impact once they've been in place for a full year in FY16, setting the stage for meeting the possibility of exceeding $700 million, which is our hope for 2016. And I'll briefly walk through how we see those dollars arriving.

The funding structure change with the City's GHI plan, which saves $58 million in 2015 we think will rise to $60 million of recurring savings. The Dependent Eligibility Verification Audit (DEVA), which we project to save $108 million in 2015 we think will rise to $115 million in 2016. The changes we made to care management program, which will

generate $15 million in 2015 we think will rise to $50 million in 2016. Changes we made to the specialty drug program, which saves $7 million in 2015 are projected to save $19 million in 2016, and the HIP rate reduction that's generating $17 million in revenue in 2015 that would otherwise have been paid to the stabilization fund for all active employees, will generate $335 million of savings in 2016. And the lower senior care rate of $38 million will rise to $42 million in 2016 and the diabetic management program implemented in 2016 is guaranteed by the vendor, as I said before, to save $3 million. So the overall cost, and perhaps we could now get to the slide that shows the costs over time. So let me see -- which is here -- yes, that was the one before. No, the one before that, the one you just had. No, the one that shows the savings. One more -- there. So as you see, if you could look at Table 4, you can see that we met the target of the $400 million 2015; that you can see that we have discussed how what we did in 2015 is going to generate $624 million that we've already identified will occur in 2016. So we have to find $76 million more; hopefully we can find more than $76 million in 2016, but what we will be

working on in the next couple of quarters is identifying those $76 million, and if you don't hear from us again until after we've reached an agreement, [background comment] invite me back, but understand the process is one that we talk with the unions to identify that $76 million and then we will announce when we have them, that yes indeed we have achieved the $700 million. But note that the $624 million that we're projecting in 2016 is projected to generate $665 million in 2017, so our target then needs another $335 million, so clearly our challenge is greater, and in 2018 we believe what we've done so far will generate $713 million, but have $587, almost $600 million to identify. And so the challenge of the process will be to find those types of savings and that we believe that we will find them and we will find important types of programs that do at least two things -- it saves money and also improves the health of our workers. And those are the things we've been finding and those are the things that we're going to seek to find.

So you see there that while we are already on our way to meeting FY16; that we're working with the unions for new programs, and I have

said; this is an ongoing process, it's an extension of collective bargaining and it's too early to say exactly which programs we have, but we are looking at them. And if we now perhaps could turn I think to the last slide and then I'm going to go back, which is -- this is the things we're talking about that we are thinking about, how do we get to that $1.3 billion of savings. So that is gonna take us into things that will be strategies -- how do we reduce emergency room utilization; how do we get savings from wellness programs; how do we enhance people using other employers, if they have a spouse with coverage or they're retired and they're working in another job; how do we deal with that; how do we reduce spending on Medicare as a Medicare Advantage program or Medicare retirees or the Medicare Advantage program; self-funding, we continue self-funding, pre-authorization programs, promotion of primary care initiatives, for instance and new health delivery systems. All of those are things that we are looking at and all of those things we think we're going to find together.

So I wanna mention one more thing, and I'm gonna go to the slide that shows the savings

versus this slide. So if everyone could take a look at Table 3 for a minute. We came to the City with the view that our health care costs, of all-in health care costs of the health care costs that include the welfare funds, include retiree costs; that was projected to be about $8 billion and that our projections were that by FY18 it was gonna cost $10.4 billion and so the blue line in Table 3 are those projected health care costs that the budget had, the financial plan had, that was the concept that the OMB viewed was the likely cost of the total health care spend, and we did the following. We have, as you've now seen, reduced the health care cost from $8 billion to $7.6 we found $400 million of savings this year and we have a plan that's gonna get us to $9.1 billion instead of the $10.4 that the health care costs are planned to get to. So to put in perspective, the costs were going to reach $10.4 billion in 2018, we believe that we've already shown how we're getting to at least $700 million of savings in 2018 and we will find at least the other 600 and so when we find those $1.3 billion of savings, we will reduce the expected health care costs by 13 percent and that is the red line that you see there,

we've truly changed the nature and the curve and bent the curve of health care costs by doing this, and it's a process that is -- I hope that you've -- I hope I haven't overstayed my welcome with taking you through at length all that we think that we're working on, but it is a complex, but it is a successful, collaborative program that we believe has changed the nature of health care negotiations in a way that no one thought possible I think when we got here 15 months ago.

So we are happy to keep you informed like we did today and I am happy to return when we have more to report and I appreciate the opportunity to be here and I think at this point I'd like to take questions from the committee.

CO-CHAIRPERSON FERRERAS: Thank you, Commissioner Linn and thank you for your very detailed presentation; it's exactly what we wanted from this committee. We have several questions we're gonna follow up, so please excuse us if you've already addressed some of our questions… [crosstalk]

ROBERT LINN: Sure.

CO-CHAIRPERSON FERRERAS: in your testimony, but it's just for clarity for the record.

But I wanted to ask, of the strategies you have pursued to achieve savings, which ones required agreement with the unions and which ones were pursuable by the Administration without agreement with the unions?

ROBERT LINN: Look, I believe that the only way to get where we're going is through a collaborative effort with the unions, so in a very real sense I believe everything we've done required a consensus with the workforce leadership and that if we divided those things into oh, these are the things that we could to without you, that would bring us back to a very traditional approach with the workforce that was not very successful in the past, and so I very much believe that the $400 million we found we found together and we're gonna find it all together. So my answer is, this is a non-traditional approach to bargaining; we have a mutual interest in finding ways to save dollars and to make our workers healthier, and that mutual interest will be exercised together; it will not be by one side or the other saying we're gonna do this on our own. So I don't believe it's an exercise that I've gone through nor I

think should go through, we are working together to find these savings.

CO-CHAIRPERSON FERRERAS: Thank you. So if you could just walk us through, we wanna specifically talk about the health insurance plans themselves. I understand that there are two providers that cover most City employees and retirees; the providers are Emblem Health, which owns Group Health Incorporated (GHI) and Empire Blue Cross Blue Shield, so to specify, let's concentrate on them. How much of the City's insurance costs dependant upon the premiums charged by Emblem Health and Empire Blue Cross Blue Shield?

ROBERT LINN: So let me start… I'll answer that one and I'm gonna let Claire, 'cause I'm sure you've heard my voice enough [laugh] this morning. But our health care costs are driven by the HIP/HMO rate, so if you multiply the HIP/HMO rate by the number of employees that are covered, that tells you how much we have to spend. The GHI rates are negotiated, but whether we get a lower GHI rate or not, the dollars, if we get a savings, those dollars go into the stabilization fund under the agreement

and that is why it was necessary to bargain changes in order to get those savings.

CLAIRE LEVITT: You know I learned very quickly when I came to this city six months ago that New York City has a very unique structure for its health insurance benefits; it's unlike any other employer or collectively bargained arrangement I had seen before. As Bob explained several times, the contribution that the City makes to health insurance is tied to the state approved HIP/HMO rates. The HIP/HMO is owned by Emblem Health after a merger between HIP and GHI that took place in 2006, but only about 20 percent of the City's employees are actually in the HIP/HMO, even though it's what drives the rates historically. The vast majority of the City's employees, about 75 percent of them, are in what's called the Comprehensive Benefit Plan or CBP. The CBP is PPO plan and of course, the HIP/HMO is an HMO plan. And very simply put, HMOs and PPOs are both managed health care plans, but PPOs offer more freedom of choice than HMOs. In an HMO environment, an HMO is a health maintenance organization, you have to see a doctor only in the HMO's network and you generally have no out-of-network benefits at all,

unless it's an emergency and you're out of the area. In a PPO, a preferred provider organization, you can still go out of network for care, but you get a lower level of benefits if you go to a doctor out of the PPO network, but you still have freedom of choice to go to whatever doctor you want. In a PPO you don't need to get a primary care provider or get a referral to a specialist the way that you do in an HMO. So the vast majority of our workforce chooses to be in the CPO/PPO plan. Now this plan is a combination of Empire Blue Cross hospital coverage and GHI medical coverage. Like the HIP/HMO, GHI is owned by Emblem Health, so we're very tied to what Emblem Health's rates are. Employees can choose from a long list of other plans that are offered by the City, but the City will only pay the HIP/HMO rate on behalf of those plans. You can choose a plan by a commercial carrier, but you'll have to pay the difference out of pocket on the monthly contribution, and that can be hundreds of dollars a month, so we only have about 4 or 5 percent of the City's active employees choosing a different plan.

Likewise, retirees can choose the GHI Senior Care plan rate, which is also a free plan and

can choose from other plans including Medicare Advantage plans, but the majority of retirees stay in the GHI Senior Care plan.

CO-CHAIRPERSON FERRERAS: Thank you. I wanted to follow up with; what are the other big determinants of cost, aside from the premiums and the number of enrollees that you had mentioned; anything else that determines cost?

ROBERT LINN: Well again, the City cost is directly driven by the HIP/HMO rate, so if we can affect the change in that rate, that has a direct cost. Things like we've been talking about of savings that we can achieve in the GHI plan, then that requires the agreement with the unions; that we don't simply take those savings and have to put it back into the stabilization fund. But many of the things that we talked about today that would affect the costs in the care management in the GHI plan are things that then would result in savings through reduction to the equalization payment.

CO-CHAIRPERSON FERRERAS: So I just wanted to follow up; if you could just talk to me on average year to year what is the contribution to the

stabilization fund? I know that you had identified some savings… [interpose]

ROBERT LINN: Yes.

CO-CHAIRPERSON FERRERAS: but if you can just talk about what we've contributed and the projection.

ROBERT LINN: So as I said, when we arrived, the projection was the stabilization fund would have $1.7 billion in it; that had been a result of contributions to the funds, ranging from $200 to $500 or more million, $600 million per year; it was projected that that would continue, that the net inflow to the stabilization fund would be 4-500 a year going forward, so very substantial numbers [background comment] were going into the stabilization fund because of the result of the HIP/HMO costing so much more than the GHI plan; clearly that will narrow that difference with the current lower projected increase in HIP, but that's the level of numbers we've been talking about.

CO-CHAIRPERSON FERRERAS: Thank you. So I mean projections of savings, it definitely is over the contribution to the stabilization fund… [interpose]

ROBERT LINN: Well many times what we're doing is we're making -- money many times -- in this process we are gonna be contributing less to the stabilization fund than we otherwise would've contributed based on agreements with the unions.

CO-CHAIRPERSON FERRERAS: Great. So I wanna talk a little bit about transparency. The savings plans represents innovative policy we can all support and the decision to secure new contracts was overdue, but the savings plan only partially offsets contracts' cost; the Administration waited seven months after announcing the program to issue a two-page progress report, which we had mentioned earlier. The Administration said last spring that we would see regular public reporting; can you address the limited reporting we have seen so far… [interpose]

ROBERT LINN: No…

CO-CHAIRPERSON FERRERAS: minus this presentation?

ROBERT LINN: So look, I believe that… [interpose]

CO-CHAIRPERSON FERRERAS: Actually, let me just say…

ROBERT LINN: 'Kay.

CO-CHAIRPERSON FERRERAS: we don't want to have to bring you in to a public hearing to get details when we see the savings moving forward, so can you walk me through what's expected in the next reports… [interpose]

ROBERT LINN: Sure.

CO-CHAIRPERSON FERRERAS: to come so that we can… [interpose]

ROBERT LINN: Sure. So look, and my sense is that it would be counterproductive to the bargaining process to describe what we're talking about while we're talking about it… [interpose]

CO-CHAIRPERSON FERRERAS: Right.

ROBERT LINN: and so the process needs to wait for us to reach agreement, as we did here. So I know there's been tremendous interest by you, by the public, by the press, tremendous interest in how we were going to find these savings and many who said oh we'll never find the savings and many who thought that we were -- this was smoke and mirror, and I have to say, I think we've demonstrated they were absolutely wrong; that in fact we have worked together quietly to find savings, we've shown how the savings, the real $400 million of savings are there

and we will continue to issue our quarterly reports, and I think you now see what we're heading towards, which is announcing how we see where we are with that year's savings, we're showing 400 now and we're now I think with complete transparency showing where we think it's gonna take you in the second, third; fourth years of our savings program, and we will continue to issue reports and I would expect that we will, as soon as we can, identify how we're going to hit $700 million or above that and that we will make that available to you and to the public.

CO-CHAIRPERSON FERRERAS: So I just wanted to kinda clarity; you were able to -- you issued one report in December, we got this report today and this presentation; the presentation obviously has more details than the report; even though the report is longer than two pages, it's five pages, so moving forward, do you think it necessary for us to hold hearings in the future savings so that you can give us these details or do you see that the future reports will have similar details after you've negotiated? I don't want to risk any opportunity of savings because you've disclosed something before negotiations have been agreed to, but at what point

will this Council be able to see the details or is it that we have a commitment that we're gonna have this hearing yearly, which I'm fine.

ROBERT LINN: Yeah. Look; it's always a pleasure to be here [laughter] and be with you. My sense would be that -- listening to what you're saying, that we can give our reports that are closer to my testimony… [crosstalk]

CO-CHAIRPERSON FERRERAS: Okay.

ROBERT LINN: include in the reports… [crosstalk]

CO-CHAIRPERSON FERRERAS: That would be fantastic.

ROBERT LINN: more information explaining what we're doing.

CO-CHAIRPERSON FERRERAS: And it could be… and as I said, after negotiations are done… [interpose]

ROBERT LINN: Yes.

CO-CHAIRPERSON FERRERAS: which we understand.

ROBERT LINN: Yes.

CO-CHAIRPERSON FERRERAS: Thank you for that commitment. I have a couple of other questions,

but I wanna give my colleagues an opportunity and the Chair to also ask his questions and I'll come back in a second round… [crosstalk]

ROBERT LINN: 'Kay.

CO-CHAIRPERSON FERRERAS: Chair Miller.

ROBERT LINN: See the lull is over. [sic]

CO-CHAIRPERSON FERRERAS: We've been joined by Council Members Rodriguez, Rosenthal and we've been joined by Council Members Levine and Crowley.

CHAIRPERSON MILLER: So we'll stay on the -- good afternoon… [crosstalk]

ROBERT LINN: Good afternoon.

CHAIRPERSON MILLER: to you and your and staff. Thank you so much for this detailed testimony here; I think that this is what the public and the Council has been looking for. So with that being said, we just wanna kinda go over some numbers and ensure that what we are hearing is what we had anticipated and that we are actually going to be able to accomplish what has been seeked [sic] out here.

So you obviously see significant opportunity for savings; the Mayor has been in office since -- 15 months, but much of the agency's level of

support and staff is new; how does this transition, and I know, obviously, by bringing on the new Commissioner there, with her level of expertise; how are we able to then transition from the past administration and what we were able to see… or not accomplish into what we're doing now, and in fact, are we carrying over some old policies and/or by bringing in a new commissioner, have we alleviated that situation?

ROBERT LINN: So I think when I arrived in January of 2014, there was a thirst from the labor leadership to engage in constructive conversation about important issues and I really believe that we have achieved that type of constructive dialogue with much of the workforce, and I think that these health savings would never have been possible without the commitment of the labor leadership to work with us and I think the concession that yes, we could find very substantial savings; same time that people say look, oh the City shouldn't have agreed to these targets without specifying how it works, the same thing is true with the union leadership; there was no clarity as to whether these targets, what would be the results, what would workers have to do to hit

those targets, so but there was a joint commitment that we would find things and find solutions. I believe that the health agreement is a perfect example of the process of labor and management working together to solve problems, so I think we've dramatically changed the approach; I wasn't here in the last administration, so I can't speak exactly what it looked like, but I do… and I do believe that bringing Claire Levitt to the City of someone who both was familiar with health benefit cost savings and labor management relations was critically important and I believe that that has moved along the process and why we have respectful conversations in our health group that we didn't use to have in prior years, as I've heard reported.

CHAIRPERSON MILLER: As it relates to the $400 million savings for this year, what part of that do you anticipate will be carrying over, including the DEVA, or other than DEVA… [crosstalk]

ROBERT LINN: Okay. So if we go back to the slide that shows the multiple years… [background comments] the… the… that slide. So as we talked about earlier, we see that $624 million will be the number that carries over from the 400 and that the --

let me get back to the actual numbers -- So the DEVA was $115 million, so I go through again that we believed that the GHI's minimum funding plan will save $60 million in 2016; that the changes to the care management program will save $50 million in 2016; that the PICA program will save 19 in 2016 and the HIP rate reduction will save $335 million in 2016 and the senior care rate reduction $42 million and the diabetic management program $3 million. So all of that adds up to the $624 million that we have identified and we are now in a process where we're gonna need to find and identify the remaining $76 million, at least.

CHAIRPERSON MILLER: So these plans were kind of built and designed and accepted because they were going to have a life span beyond Medicare that they were… [crosstalk]

ROBERT LINN: Yes. Yes. Yes. And remember, the approach that we're taking is this incremental increase in savings that goes from 400 to 700 to a billion to $1.3 billion, or growing $300 million each year. So the target gets bigger each year, so we need both a combination of recurring savings from we do in any year and then additional

savings in the next year, and that is the purpose, is that by the time we get to Fiscal 2018 we will have $1.3 billion of recurring savings, 12-13 percent of the projected cost of the plan; those would need to be recurrent, so we need things that will continue to save money over time.

CHAIRPERSON MILLER: Okay. So my understanding of the May 14 agreement that there is no reduction to the supplemental or welfare benefits; is that correct?

ROBERT LINN: There is no reduction to welfare funds as part of this health agreement.

CHAIRPERSON MILLER: Is it also correct that those benefits are administered by the unions?

ROBERT LINN: Yes. Yes, the welfare fund benefits administered by the unions… [crosstalk]

CHAIRPERSON MILLER: In all cases and… [crosstalk]

ROBERT LINN: Yes, multiple welfare funds… [crosstalk]

CHAIRPERSON MILLER: Okay.

ROBERT LINN: each union has their own welfare fund… [crosstalk]

CHAIRPERSON MILLER: Right.

ROBERT LINN: Yes.

CHAIRPERSON MILLER: So does this plan include savings from those welfare funds as well?

ROBERT LINN: No. What the plan includes is an agreement that we will look at central purchasing as a way of possibly saving prescription drugs. In the world outside of New York City, prescription drug cost is an area that many, many employers look to to find substantial savings; it's an area we should be looking at also. If we find those savings, then we'll discuss with the unions what's the best way of using those savings. But we are interested in looking together with the unions at some central approach on prescription drug purchasing.

CHAIRPERSON MILLER: So this potentially could be part of the gain-sharing?

ROBERT LINN: It potentially could be.

CHAIRPERSON MILLER: Can you talk a little bit about the Well-Care program that you anticipate putting… [crosstalk]

ROBERT LINN: The wellness program.

CHAIRPERSON MILLER: Yeah, the wellness program… [crosstalk]

ROBERT LINN: Yeah.

CHAIRPERSON MILLER: is… I'm sorry, and will that program be provided by the current providers?

ROBERT LINN: So I think this is under development at this point and we are working, we have several agencies who are coming together to work on what are the types of things that we can be thinking about, us with the Department of Health -- what are the types of things we could be looking at for the workforce and how that -- and so this is really -- other than the -- the first thing we did was the flu shot and I think that's an example of a program that we were able to implement very quickly and was widely accepted and appreciated and so we're going to be working in other areas as well -- and Claire; you wanna add something to that?

CLAIRE LEVITT: We're really looking right now very comprehensively at what other municipalities and other private employers have done in the wellness arena. We're looking in general at doing health risk assessments and biometric screenings to help identify people who have health problems. We're actively moving forward with the

pre-diabetic prevention program, which is a CDC evidence-based program that's been implemented nationally and we're looking at doing it a little differently; they haven't been able to get a lot of interest in the program when they've taken it out in the communities; we're looking at trying to bring the program to the worksites to get more interest in the program, and also offer an online version of it, which we think will get more people interested in it. We're looking at programs like Nurse Line, which is actually available to us as part of the Empire Blue Cross program, but it hasn't been properly publicized, so nobody knows about it. So we're looking at health information programs, tele-health programs; generally more education. We're working with the Parks Department on doing fitness programs, like their Shape-Up program and taking it to the worksites, we're looking at walking programs, maybe walking challenges for the City employees; we're also looking at food program possibilities like Weight Watchers at work, implementing different food policies at the worksites, we're looking at programs that will reward healthier eating and we're looking at different ways that we can reduce stress, because

of course none of us have [background comment] any stress at our jobs.

CHAIRPERSON MILLER: But it appears that most of this undertaking would be the responsibility of the Administration as opposed to the health care provider; is that the case or is it -- 'cause I'm looking at… but you talked about looking at other municipalities and we're looking at some of the best practices of not just other municipalities, but some of the authorities of agencies within the region and some of the things that they have done recently, and I understand that some of this stuff requires RFP and we're tryin' to stay away from that portion, but can in fact those things that you were just articulating, can they be delivered if they were being administered by the City and does it require additional personnel?

CLAIRE LEVITT: We're looking at a combination of programs that can be delivered by the health insurers, something like the Nurse Line; something like the Diabetic Case Management program, are being delivered by the City's vendors under the health insurance contract; there are other things, like our worksite initiatives that may be administered by the City; we want to work through

labor management committees and labor management cooperation in order to get these programs going at all the different agencies. So I think there isn't one answer; that a wellness approach is many, many different programs and that we're going to look at it from both the insurance company perspective, other outside vendors and internal resources.

CHAIRPERSON MILLER: Okay. And I'm gonna just finish up here. But is there a joint labor management committee that has been set up to evaluate the impact of the quality of the services that are being delivered and some of the savings initiative programs? As I've read through the testimony this morning and saw some of the things that were being done, and particularly as it pertains to reducing emergency room visits; in other words, how do we then quantify the value of the services being delivered as it relates to its intent? Are we losing and who decides that; is there a committee that is in place that is evaluating all that we're seeing today?

ROBERT LINN: So we do have this labor management committee; there's the MLC Health Committee and then there's a technical group that reports to the overall health committee. One of the

things that Claire has brought to us is the tremendous desire to look at data together and analyze health care data of labor and management in actuaries working together to look at data. That is something we're going to be doing, because that is something that most employers around the country look at data, constantly analyze data, see where their costs are coming from, see what providers provide the most efficient delivery of services; they're all things that people do that New York City needs to start doing, is looking at data together, and so we're going to moving in that direction. So yes, there is a committee to look at these types of issues and it's a subcommittee of the MLC Committee and we will be looking at data together.

CHAIRPERSON MILLER: And finally, what is the payout on the opt out program? [background comments]

CLAIRE LEVITT: Right now the payout is… [background comments] it's $500… oh… it's on. It's $500 for an individual and $1,000 for a family.

CHAIRPERSON MILLER: And what is the monthly cost of a premium?

CLAIRE LEVITT: The monthly cost is about $6,000 for an individual and about 14… [crosstalk]

ROBERT LINN: The annual cost.

CLAIRE LEVITT: the annual cost about $14,000.

CHAIRPERSON MILLER: Well I would submit that if we wanted to get more people to opt out that that would be a place to start… [crosstalk]

CLAIRE LEVITT: That is something we are absolutely looking at; we've been compiling some data on what the average cost of employee -- if employee contributions are to other employer's coverage in the city and we wanna come up with… we wanna come up with the right dollar amount that will help incentivize people to choose other coverage.

CHAIRPERSON MILLER: Yeah, 'cause that's not really an incentive to leave… [crosstalk]

ROBERT LINN: Right.

CHAIRPERSON MILLER: But do they… [crosstalk]

CLAIRE LEVITT: Right; right now it's not enough of an incentive to give up free coverage… [crosstalk]

CHAIRPERSON MILLER: at that point, they maintain their supplemental benefits… [crosstalk]

ROBERT LINN: So we agree; we agree that that is fertile ground for us to look at.

CHAIRPERSON MILLER: Okay. Okay. Thank you so much.

ROBERT LINN: You're very welcome.

CO-CHAIRPERSON FERRERAS: Thank you, Chair Miller. I'm gonna have… I have two quick questions. We've been joined by Council Member Johnson, who is also in queue for questions. So in the agreement the Administration and MLC are required to hire outside expert help to develop a measuring tool, calculate and track health care cost savings; where are you in that process?

ROBERT LINN: So each labor and management hired their own actuary at this point and so we are now, we've hired Milliman and the unions have hired Segal, and they are working together with the committee and will work together to analyze information together. So that's where we are at the moment; is there are two actuaries working with us.

CO-CHAIRPERSON FERRERAS: And was that negotiated that you would have different actuaries or?

ROBERT LINN: No, no; the original intent was that we would have a single actuary and we just decided that at this point we would work with two actuaries.

CO-CHAIRPERSON FERRERAS: Okay…

[crosstalk]

ROBERT LINN: That's the nice thing about collective bargaining, is one can decide to go a different track if it makes sense and at this point people are more comfortable with using two different actuaries.

CO-CHAIRPERSON FERRERAS: And if the two actuaries come back with two different results, then you negotiate on both of those?

ROBERT LINN: So far that hasn't happened.

CO-CHAIRPERSON FERRERAS: Well good; I hope it doesn't. So… I'm sorry; I have post-its and a whole bunch of stuff here. I have one more question and then we're gonna have Council Member Rodriguez, followed by Council Member Johnson.

The culturals is something that has come up in the past in a different way with these health care savings and they seem to have budget implications when it comes to the cultural, so how will you address the health care [background comment] savings for the cultural institutions that are very important to this Council… [interpose]

ROBERT LINN: Sure.

CO-CHAIRPERSON FERRERAS: obviously to our city, but they're in a very tough situation when it comes to these savings that were kind of imposed or implemented on them, but with no real strategy or funding.

ROBERT LINN: So I'll start and then Ken will decide whether I've done it adequately or not. But some of the savings that we have negotiated will flow through to the culturals and they'll be the beneficiary of some of the areas of the savings; others will not and we're gonna need to come up with a way to account for that. We do believe that we're gonna treat the culturals fairly and that they will get the funding they need to make the settlement, but we will be able to get the health care savings that

we have negotiated. You wanna add to that? [background comment] Okay.

CO-CHAIRPERSON FERRERAS: So I know that you said some of the savings and I'm a stickler for detail, so would you be able to give me more detail on what percentage or [background comments] or what that means and then when you say that they'll be held whole, I think it's a year later; I know that we were talking about this in the last budget process, so at what point in time will they be held whole and obviously there has to be some type of advancement of monies right now because we're beginning the second budget process and I'm sure that we're going to be engaging in those full conversations again?

KEN GARDINER: Right. I mean the example of something that would flow through would be the HIP rate. So since the… [interpose]

CO-CHAIRPERSON FERRERAS: I'm sorry; can you speak up?

KEN GARDINER: I'm sorry. If we get savings through a reduction in HIP rate, since the cultural institutions pay those premiums directly themselves, those savings will flow through as a cost reduction to them. On the other side, if we have

something like the GHI minimum premium, which essentially reduces the City's contribution to the stabilization fund, they would not all automatically participate in those savings and we would have to make them whole for that share of the offset that we took when we initially funded the settlement.

CO-CHAIRPERSON FERRERAS: So timeline; can you walk me through when that would happen? I know that we're engaging with the culturals on their fiscal needs and they need to understand whether this will be one of their asks that they need to make to the Council, so when do you identify that you'll be able to address the lack of share benefits; not benefits, but the shared savings from GHI?

KEN GARDINER: Yeah, I mean now we've announced this and come up with this report we can start publicly parsing through which portions are gonna flow through and which are not and establish the process for making the culturals hold to extent there was not a path through.

CO-CHAIRPERSON FERRERAS: And how do you view engaging with the culturals to explain to them this process?

KEN GARDINER: I imagine that what we'll do is we'll go through this, figure out the what's in and what's out portion and come up with an original analysis that we'll share with DCLA, who will share with the cultural institutions; that's our normal process.

CO-CHAIRPERSON FERRERAS: Okay. And you'll share this with the Council, this process?

KEN GARDINER: Sure.

ROBERT LINN: We'll have a mechanism…

CO-CHAIRPERSON FERRERAS: Right.

ROBERT LINN: to assure what you're looking -- to what everyone wants to assure…

[crosstalk]

CO-CHAIRPERSON FERRERAS: Right.

ROBERT LINN: and then we'll make that mechanism public and share it with you.

CO-CHAIRPERSON FERRERAS: Okay. Thank you very much. We're gonna have Council Member Rodriguez for his questions.

COUNCIL MEMBER RODRIGUEZ: Thank you, Chair. Commissioner, how much… when you look at the data, what percentage of members from all the unions that you have been able to negotiate this contract,

and I have to give credit to this administration and to your team, because you know being a former teacher, I lived for so many years without a contract and I know how critical it is and witness after being a teacher to be a council member and see how the previous administration treated our public employee, keeping them without contracts for so many years, you know this is like a new day in our city and I think that the whole argument in the past, which was, we cannot negotiate this contract because we don't have the money to do it, now to see that this administration has been able to assemble a team of people and have you coming in front of us to say this was possible, not only this was possible to settle this agreement, but we will have the funds to continue negotiating with the other ones, so this is, you know, probably one of the areas where we can that this administration will leave a legacy in our city and we are grateful and we thank what Mayor de Blasio and your team have done. But my question is on GHI; as someone that carries GHI, and I know that reading how the company promoted themselves, saying that members who carry GHI, they can get services from any top doctors in our three state [sic]; however, that's

not the reality. You know, I can tell you; I have witnessed; I have lived as someone who carries GHI, that doctors affiliated to Columbia Presbyterian, they don't take GHI; that doctors affiliated to the best institutions, they don't take GHI. So how can you use the power of investing in those other insurance and make them to get a largest numbers of their doctors affiliated with those prestigious institutions to also say we can get so no [sic] doctor also to take patients who only have GHI?

ROBERT LINN: So let me say two things and then see if anyone else wants to add to that. First I want to thank you for the kind words about the efforts we've made in collective bargaining; it has been a central focus of this administration; the team that I work with has just worked constantly, day and night, seven days a week, any times to make these settlements, so it's terrific to hear those kind words.

I have thought, in dealing with health, that we have 350,000 workers, we have a million lives covered by the city health benefit plants; we ought to be able to have the most effective, most efficient health care plans anywhere, there are very few

purchasers like we are, and so one of the things that we are going to be getting to is how we improve the health care that we give in a way that we can afford. So clearly, limited numbers of hospitals, limited numbers of panels, that's the way insurance companies get savings, so it's impossible to be unlimited and still contain costs. On the other hand, are we doing it in the best and most efficient way, most effective way; are we precluding the ability to use some care providers that are both really effective and really efficient; those are the things we need to look at and we will be looking at over time. Anything you wanna… [interpose, background comments] So do we agree? I don't know; I do know that we should be looking at who are the most efficient and effective providers and that that is important that we make sure the most efficient and effective providers are part of our plan, that is something we need to get to.

CLAIRE LEVITT: A new health plan hasn't been looked at for decades; we've been in the CBP plan for most of our employees for a very, very long time and I think we finally have an opening now to look at new alternatives and that looking at a new

health plan is one possibility; another possibility is working with GHI to get them to expand their panel of doctors. I think we -- all of these issues come up with our discussions with the Municipal Labor Committee and I think we'll be moving forward on all of them. I'm concerned about looking not just at the number of doctors, but at the quality of the care that our employees are getting.

ROBERT LINN: Thirty-three… I could say this; 33 years ago I was much young and on the OLR staff and involved in health care negotiations where we agreed with the unions to use GHI, CBP and the HIP/HMO, and so 33 years later we are doing things the same way the City did it 33 years ago; these things need to be looked at and we now have the ability to work with the unions to do that.

COUNCIL MEMBER RODRIGUEZ: And so again -- we can look at it; as someone, again, in my five or six years as a council member I have GHI, as my 13 years as a teacher I had GHI; I can tell you that what GHI is providing right now is completely different than what they provided 10 years ago; that many of the best doctors, they don't take GHI, especially those doctors affiliated with those

hospitals. So what I hope, that when we look at that equation, how much of the labor contribute, how much that the City contributes, but also we look at the equation of the insurance company and then go together and have that conversation with them and say, we need you guys to get most of your doctors also to take some of those, you know, provide those services too.

My last question is very short. How many more unions are you currently in negotiation and how much money are you looking to invest in order to say we have settled with a 100 percent of the labor that the previous administration failed and did not settle the contracts?

ROBERT LINN: So we're through 76 percent of the workers, which leaves 24 percent and I think around 80,000 workers still to go. We have two patterns, a civilian pattern and a uniform force pattern and we believe that those are the dollars that are going to be needed and we funded those dollars in our labor reserve and we do not intend to spend more than that. We do face an arbitration with the police and we believe that we will sustain our

position in that arbitration with the police.

[background comments]

CO-CHAIRPERSON FERRERAS: Thank you. And I know that you provided a list to us a month ago; would you be able to provide the Committee an updated list?

ROBERT LINN: Sure. Sure… (CROSS-TALK)

CO-CHAIRPERSON FERRERAS: Thank you. Council Member Johnson.

COUNCIL MEMBER JOHNSON: Thank you, Chairs for having this important hearing. Thank you, Commissioner Linn and Deputy Commissioner Levitt.

I wanna raise an issue, 'cause I think it's important to raise publicly that I raised that the OMB budget hearing that Chair Ferreras had at the beginning of March. I've only been on the City Council for 15 months; my first day here, filled out my forms, got enrolled in GHI; I'm HIV positive, I have to take three pills every day without fail, I cannot miss a single pill; fill it out, you can go downstairs to the Duane Reade across the street at 250 Broadway, go fill your prescription. Went downstairs, brought my prescription to the pharmacist; we'll be with you in seven minutes,

you'll have your prescription, Mr. Johnson. Thank you. Mr. Johnson, your prescription's ready. Okay, great. Thank you. Co-pay $15 or some… that's $2800, Mr. Johnson, $2800. I said what are you talking about? They said, your GHI plan requires that you receive these drugs through mail order catalog and you are not allowed for, HIV medications, to fill these at a pharmacy or you have to pay full price. So I said, "Well I need the drugs now." Sorry; call GHI. I then went upstairs to our wonderful Human Resource Department at the Council and Peg Toro, who's a saint here at the Council, spent three-and-a-half hours on the phone with GHI to try to get them to allow me a waiver for the day so that I could go downstairs, pick them up, but that then they would require me in the future to receive my drugs on a monthly basis through mail order. So we did that; I went downstairs, they gave me a one month subscription [sic]; I paid my co-pay and that was it. Then I had to set up my mail order; if you're not home they can't drop them off; I don't live in a building with a doorman, so I now have them delivered to my office; it has been a mess and I'm lucky enough that I work at a place where we have a large central

staff, a great human resources department that handled this for me, but for the average New Yorker who is part of our government, who are part of these unions, this is a very painful, difficult thing and so I really just wanna understand if other New Yorkers are facing similar problems, if you're hearing from other people who are being denied at pharmacies or you think could be denied moving forward, given the contracts that were ratified, where they potentially may be denied drugs, which I wouldn't consider the life-saving drugs I take every day to be specialty drugs, they're life-saving drugs. So I just wanna hear a little bit about that and see if you guys thought about this when this part was being negotiated? I know that you said that changes were made to the specialty drugs program in FY 2015 that are expected to save $7 million and that's projected to increase to $19 million in 2016; is that because of situations like this, where people are being denied at pharmacies and being forced? Thank you.

ROBERT LINN: So let me speak generally and then maybe Claire could speak specifically.

I have not heard an issue like that before; we have a health benefits program at OLR and so one of the things that could have happened is to call OLR, the Office of Labor Relations, and say look, I have this problem; can you help me find my way through… [interpose]

COUNCIL MEMBER JOHNSON: How many people know to do that?

ROBERT LINN: Well I think, you know, generally most HR people know to call OLR, so I… 'cause I haven't heard this before; I mean so it's not like I've heard a thousand examples of people with very important stories, you know and narratives that need to be dealt with, and so clearly my reaction to hearing that is we will look into that and that that shouldn't happen and that our plan to get savings is not to deny coverage; that's not what we're all about, we're about the opposite, we're about the belief that workers should get coverage and through effective health care coverage we will save money in that process not by simply saying people are never gonna use it or have co-pays at levels that people then don't take prescription drugs that they need or don't go to physicians when they need to go

to physicians. So our approach is that that shouldn't happen and so we will look at it… [interpose]

COUNCIL MEMBER JOHNSON: Do you think that an individual who is HIV positive should be able to go to a local pharmacy if they're on the city plan and get their drugs filled at a pharmacy?

ROBERT LINN: I don't know the answer to that; I believe that people who… I believe… [crosstalk]

COUNCIL MEMBER JOHNSON: You can't say yes to that?

ROBERT LINN: No, I believe that people who have medical needs should have a process that gets them the medication they need when they need it; I believe that should be; I don't know… I don't know… I don't… [crosstalk]

COUNCIL MEMBER JOHNSON: And could that include going to… Could that include going to a pharmacy if you're HIV positive and pick up your medicine?

ROBERT LINN: I know there are many, many plans that insist on mail order and it could be that

there need to be certain exceptions when people don't have the ability to receive a mail order… [crosstalk]

COUNCIL MEMBER JOHNSON: And have you found exceptions for certain drugs that people… [crosstalk]

ROBERT LINN: I haven't…

COUNCIL MEMBER JOHNSON: should be able to pick up instead of get through mail order?

ROBERT LINN: I haven't heard this issue before. Now that you've provided to explain the issue, we'll look at it.

COUNCIL MEMBER JOHNSON: But you don't think that… you can't say without any doubt that you think that someone who has a chronic condition that may not be able to wait for mail order, they shouldn't be granted an exception to pick up at a pharmacy?

ROBERT LINN: But you were granted an exception. If… [interpose]

COUNCIL MEMBER JOHNSON: I mean not just always going through mail order; sometimes -- no offense to our postal carriers or to insurance companies -- sometimes you don't get in time;

sometimes it doesn't show up on the day they said it was gonna show up.

ROBERT LINN: So I must admit, prescription drug by mail order is one of those things that saves dramatic money for virtually all employers in the country, they all use it. I must admit I have prescription drugs that come through the GHI process and I get it timely, Express-Scripts, I get it timely, I get it early; I have more pills than I know what to do with from early delivery. So experiences can be different; your experience needs to be looked at and we will.

COUNCIL MEMBER JOHNSON: Well… [interpose]

CHAIRPERSON MILLER: Excuse me, Council Member. 'Kay so, correct me if -- there was -- up until last year, that was a state law mandate that to use -- for maintenance drugs that you use -- that is no longer the case; that you are now allowed, if your plan allows for you to go into the drug store and purchase your drugs from the drug store; you're no longer mandated by state law that the provider, administrator requires you to use the maintenance drugs through [background comment] the mail order any

longer, so I think this is kind of new that -- it's about plan design again and I think a lot of what we've been talking about was plan design and that's certainly something where there is a savings; you know, I have experienced that in past, but I think that's the reason why that they've kind of amended that position that requires seniors and others who have had difficult time with mail orders do so and I think that the City should be in keeping with the rest of the state and kinda keep up with and at least investigate the possibilities of making that happen.

ROBERT LINN: We will look at it.

COUNCIL MEMBER JOHNSON: May I just say, Commissioner Linn, I am not trying to in any way diminish I think the incredibly important work that you have done over the last 15 months achieving these I think very good contracts with our municipal workforce, four-fifths of the workforce, I think it's a big deal; I congratulate you for that, so I'm not trying to rain on that parade, I just can tell you as someone who has a chronic condition, when you go through an experience like this it's very difficult, it's painful, it's hard and I don't think this is the first time that you heard about it, because I

mentioned it at the OMB hearing and Deputy Commissioner Levitt was very sweet and came up to me and said that you guys would look into it and so I would hope that someone will look into it. I'm not just talking about my circumstance, I wanna understand -- for me, I worked it out; now I have it delivered to my office; sometimes still there are problems, but I wanna understand if this is happening in other places, because I raised this exactly a month ago at a public hearing with you and with Dean Fuleihan and I didn't get any follow-up from it. So thank you. Thank you; I don't wanna belabor that, but thank you.

ROBERT LINN: We will look into it and we'll get back… [crosstalk]

COUNCIL MEMBER JOHNSON: Thank you. Thank you.

ROBERT LINN: and we'll get back to you. The last thing I have -- one more quick question -- is, I think one of the unions that you've been working with for a while now, but we still haven't achieved a contract with, is the Doctors Council, which you know works in HHC facilities, they've been without a contract for many, many years; each

hospital's a little different, I know there are complications around that; I wanted to just see if you had any update and projected timeline on when you think we'll be able to see a final contract with the Doctors Council.

ROBERT LINN: I'm optimistic. We… [crosstalk]

COUNCIL MEMBER JOHNSON: Does that mean soon?

ROBERT LINN: We're having conversations and hopefully we will work something out, but we are having a number of conversations with Doctors Council and we are very much in progress with them.

COUNCIL MEMBER JOHNSON: But you've been having conversations for quite a while now; do you feel like there's been progress made on both sides?

ROBERT LINN: Feel like there's been progress made.

COUNCIL MEMBER JOHNSON: So do you think we could see something before the budget's adopted?

ROBERT LINN: I don't think I ever can announce when things are gonna happen before they are public or before the union leadership would want it

public; we are having productive conversations with them.

COUNCIL MEMBER JOHNSON: Well the Doctors Council; these doctors work in some of the most difficult facilities; they have not gotten an increase in many, many years, you know, retention is difficult now because of this issue; people are feeling upset, doctors are leaving, it's become a very significant issue and I think the quicker that the City can resolve this, the better for our hospitals, the better for our patients, the better for our city, so I look forward to getting a good resolution between your office and the Doctors Council on that.

ROBERT LINN: We also believe it's very important to get a settlement soon.

COUNCIL MEMBER JOHNSON: Thank you very much. Thank you, Chairs.

CO-CHAIRPERSON FERRERAS: Thank you, Council Member Johnson. I just wanted to follow up; in your testimony you stated that one of the ways you've achieved savings was through the restructure of the GHI medical plan; going from a fully insured program to a minimum premium plan. Can you elaborate

on this and explain any potential effects on quality of service that this switch has had… [crosstalk]

ROBERT LINN: Right; this has no impact on the delivery of service; this is purely an issue of how it's funded, tax implications; will have no impact on quality of service.

CO-CHAIRPERSON FERRERAS: Okay. I wanted to talk about the -- in the agreement the Administration and the MLC are required to hire -- I'm sorry, we're gonna -- I wanted to talk to you about the arbitrator. It is my understanding that the arbitrator would step in in the even of a dispute if a dispute is not resolved within 90 days and terms of the dispute is not defined in the agreement; what would you consider or what is being considered a dispute and at what point does a disagreement rise to a level of a dispute; who determines when a disagreement becomes a dispute?

ROBERT LINN: So first of all, the arbitrator -- there's two sections; one is the arbitrator has to decide within 90 days; the other is that the arbitrator can also either sit at the end or give interim relief, which means that at any time one party or the other could say look, there's a problem;

we wanna go to the arbitrator, so that one side could say look, we believe we're not getting the $700 million for next year, we wanna arbitrate; the union has every ability to respond and say at this point, look we think it's premature; we're not even in that year. But to the extent that dollars are not met, the obligation is not met, there clearly is a right to arbitration and it doesn't need to wait till the end… [interpose]

CO-CHAIRPERSON FERRERAS: And have you identified an arbitrator?

ROBERT LINN: Oh yes; it is named in the agreement as Martin Scheinman.

CO-CHAIRPERSON FERRERAS: Martin Scheinman. Thank you. I wanted to -- I have one more question and then I'm gonna give it back to the Chair. The City's health insurance is dominated by two firms; the prior administration tried to put insurance out to bid, but it left labor out of the loop and the plan went to court. The City is thinking of issuing a request for proposals regarding health insurance; what are the next steps and the timeline for that RFP?

ROBERT LINN: So first of all, we are not going to do anything unilaterally; the nature of this process is that we work together to decide what makes sense and then we go out together to do whatever makes sense and to bid certain elements. We actually are bidding one element of the plan, care management and so I think that's a nice change that we've already begun to agree that we can bid and that we would look at it. We will look at issues over time and I mean as you see from that slide, [background comment] we're now in the -- two-thirds of the way through that first left column there's a lot of time and a lot of issues that we're gonna need to deal with and I think that we will come together to decide what are the things that make sense and when to do it, but we will agree with the unions how and when.

CO-CHAIRPERSON FERRERAS: Great. The RFP timeline for the care management; what is that looking like then?

CLAIRE LEVITT: Our plan is to have a new or if the existing care management vendor is reassigned to it, by January 1, 2016. [background comment] So the RFP should be posted probably sometime this month or next month; then we'll be

interviewing candidates and implementing whoever the new vendor is for January 1.

CO-CHAIRPERSON FERRERAS: Thank you. You mentioned that the two actuaries that we had -- I just wanted to follow up; are they developing a measurement system that at least responds to some similarities in their findings and what will that look like and how will it differ from the baseline you mentioned in your testimony?

ROBERT LINN: We haven't had any disagreement on the numbers so far, so both actuaries are involved and we've agreed together that we've reached the $400 million and the budget will so reflect, and OMB will so reflect in the -- already reflects those [background comment] savings. So it's… [interpose]

CO-CHAIRPERSON FERRERAS: But do you…

ROBERT LINN: If… If there were disagreements… [interpose]

CO-CHAIRPERSON FERRERAS: Right. Thank you. Right.

ROBERT LINN: If there were disagreements, [background comment] then we would either reconcile them between the actuaries or I

suppose we would go to an arbitrator if there was a disagreement that we need to -- and go to the arbitrator, Mr. Scheinman, if we needed to. But I don't envision it happening; I believe that there will be an effort that we will solve those problems through labor management discussions. And this is not unique; there are other unions that have labor management relationships that have experts that work together and we're achieving that.

CO-CHAIRPERSON FERRERAS: Great. Thank you. Chair Miller.

CHAIRPERSON MILLER: Thank you, Chair. So in lieu of an RFP in general for health benefits, are we looking at some form of plan design, because I know there were a number of things that were mentioned about how do we achieve a richer or more robust network; obviously there's some ideas that would require plan design and would also probably require those providers to pay a little more to attract those types of services that were mentioned by the Council Member earlier. Also, as it pertains to plan design, I just wanted to -- the Commissioner mentioned something about when you were defining specifically the HMOs and PPOs; I think that you left

out that those are often variables depending on the plan design and are not necessarily finite whether or not things like whether or not you had a gatekeeper, whether or not you had certain deductibles and so forth; depends on the plan design, so the quality in service that are being delivered to the membership and to City employees such as myself, obviously we are recipients of this benefit package as well, so what conversation are we having with those providers around plan design as we move forward?

CLAIRE LEVITT: We are having discussions about plan design and one of my goals is to use plan design to help drive people to make appropriate health care choices, so some of the discussions that we've been having are around things like maybe we would raise the emergency room co-pay and decrease the primary care co-pay so that we would help people make better decisions about going to primary care or urgent care centers rather than the emergency room; we don't have agreement on these strategies yet; we're talking about them and beginning to talk about the numbers; we're going to need to see the data to help us understand better where people are going and if it's appropriate, but we do wanna use the plan

design not just to shift cost to employees, but to help them go to appropriate places.

ROBERT LINN: So let me just say; obviously this is the type of discussion that you have in this health care group and what I wanna assure you is we are having those conversations and the elected leadership of the employees and their technical experts bring exactly those points to the table and in fact we are engaging with them of what are the… 'cause we have now a mutual interest in effective, efficient delivery of health care and so these types of topics are of course relevant and topics that we will discuss.

CHAIRPERSON MILLER: Well, I think that, with all due respect, what you mentioned is standard industry practice in raising the emergency room fees; I think that we're probably the only ones that's not doing it as a deterrent from keeping people to use it, but the other thing is that you have to have viable alternatives… [crosstalk]

ROBERT LINN: Yes.

CHAIRPERSON MILLER: within communities so that folks… [crosstalk]

ROBERT LINN: Right.

CHAIRPERSON MILLER: and then they have to be educated that we have this, and I think that the well care is absolutely the way to go and it is fabulous and I think the sooner we engage the better, but again, I was talking about plan design in terms of better delivering services; how do you enrich a network that you wanna keep people in? And so I'll leave that there and kinda digress and talk about the high option rider plan that is available. Now if in fact -- are those providers involved in the high option rider, are they adhering to the HIP standard as well, the rate?

ROBERT LINN: The employer pays the HIP/HMO rate; isn't the high option rider paid -- is above that [background comment] and is paid by the employee, the extra cost for that rider is paid for by the individual employee.

CHAIRPERSON MILLER: So what I'm getting at; it's cost prohibitive in the way that it's impossible to do if in fact -- say for instance you had children out of state which required you to have a different health care provider, I have seen experiences where in order for you to have those health care providers with are utilized by… excuse

me… utilized by agencies throughout the region here cost as much as $500 bi-weekly and that would certainly make it cost prohibitive to have appropriate health care for one's family, so how do we address those issues?

ROBERT LINN: So let me offer this; I do believe that that is part of the reason why there are HR professionals at each agency and why we have in Office of Labor Relations a Health Benefits Division. To the extent that people have individual issues in terms of what is the appropriate plan or are there ways of minimizing cost; perhaps there are ways that we can be helpful in that, and I think that that's something that we ought to make that employees know that they can ask for assistance with that. But that we have a series of plans out there; two, as you know, are completely free and two have employee contributions that are necessary to pay for it and whether or not there's a free plan that can provide exactly what employees want, most employees I think do feel that they have pretty good coverage with the City and that it's a pretty good buy by the very fact that people don't opt out and use other employers' plans; they vote with the plan that they use. But we

are always looking at ways we can be more effective, that is for sure.

CHAIRPERSON MILLER: So based on your answer, I would think that somewhere along the line there was a survey that quantifies all that you just said, that folks are really happy with the benefits that they have; that there aren't folks with out-of-state dependents that can't access health care because of this and… [crosstalk]

ROBERT LINN: So…

CHAIRPERSON MILLER: and… and… and… and… let me finish. So this obviously is a matter of negotiation; I'm certainly not negotiating now; I'm merely saying that what is available to New York City employees now in that situation is cost prohibitive and in fact, they are being held to a standard that are provided by whether it's a state standard with HIP or locally; how do we address that so that we can provide; so that we can pay a little more and that folks don't have to really decide whether or not they're gonna have health care for their dependent and themselves or whether they're gonna provide for other critical living services?

ROBERT LINN: Look, employee surveys are always interesting to me; they generally would require union agreement that we do it, but at some point in this process, finding out more from the workers how they feel about what they're getting I think is an interesting possibility, but again, it's a thing that we couldn't do unilaterally, wouldn't do unilaterally; it's something we would talk about in the health care group.

CHAIRPERSON MILLER: [background comment] I only mentioned that because you sound pretty emphatic when you said that everybody was happy with what they had. [laughter] So let me just -- and my final question is; the other 24 percent bargaining units that are without a contract, where do they fit into this equation?

ROBERT LINN: Where's the end?

CHAIRPERSON MILLER: The other 24…

ROBERT LINN: Yes.

CHAIRPERSON MILLER: percent; where do they fit into this equation; are they included in these savings or does that number increase because of what they're doing; how does that work…? [crosstalk]

ROBERT LINN: The… The MLC agreement was on behalf of the entire workforce, so they are included in these savings.

CHAIRPERSON MILLER: Okay. I thank you so much; I thank you.

CO-CHAIRPERSON FERRERAS: Thank you, Chair. I just wanted to follow up with what Council Member Johnson said, and I… you know, obviously this is a very complex process, but I've gotta believe that in him deciding to have his medication sent to his office that there may be other New Yorkers that are doing the same because of the challenges that we have with our mailing system -- whatever, doorman; no doorman, but there is something to be said and while I understand that E-Scripts doesn't send out a box that says what the medication's for, but if you see someone getting a monthly package, it's obviously something chronic or something that they need to take medication for, and I would think that in the spirit of privacy and at least giving workers some type of option that you would take into consideration, giving some or those who opt… who have complex delivery issues, that maybe they could have an option to go to their pharmacy as opposed to participating in E-

Scripts for confidentiality and also for the conve… less so for convenience; more so for confidentiality, which I think is what we would want to protect?

ROBERT LINN: We will look at this.

CO-CHAIRPERSON FERRERAS: Thank you. We've been joined by Council Members Van Bramer and Cumbo. Thank you very much for coming to testify today; it is… [crosstalk]

ROBERT LINN: You're very…

CO-CHAIRPERSON FERRERAS: 12:30; it wasn't too bad, I think. I really appreciate your detail; it's exactly what this Committee expected and wanted; we however have other questions that we're going to be following up with you in a letter… [crosstalk]

ROBERT LINN: 'Kay.

CO-CHAIRPERSON FERRERAS: and thank you for coming today.

ROBERT LINN: So I really appreciate the opportunity to be here; I think this was very important and very useful for everybody for me to have this opportunity to speak about these issues, so thank you for inviting me.

CO-CHAIRPERSON FERRERAS: Thank you, Commissioner.

We are gonna call up the next panel; we will now hear from Maria Doulis and Dr. Sherry Glied. Thank you.

And if there's anyone here that wishes to testify, please be sure to see the Sergeant at Arms to fill out your form.

[pause]

CO-CHAIRPERSON FERRERAS: We're actually gonna take a three-minute break in-between the next panel, three minutes; we will be back in three minutes.

[pause]

CO-CHAIRPERSON FERRERAS: Thank you for coming; we're resuming… [background comment] our hearing on health care savings and we have a panel of two experts who will begin their testimony -- we have his testimony, yes -- who will begin their testimony; if you could just state your name before you begin so that we have it on the record. Thank you. You may begin.

MARIA DOULIS: I'll go first. Hi, I'm Maria Doulis; I'm the Director of City Studies for

the Citizens Budget Commission; the CBC is a nonprofit -- Oh; do you want me to go on? Okay -- is a nonprofit, nonpartisan civic organization that serves as an independent fiscal watchdog for New York State and New York City governments. Thank you for the opportunity to testify today.

Before addressing the agreement, I want to note why this is an important issue. As CBC has noted, the cost of the City's health insurance plan has grown rapidly in the last decade; since FY 2005 cost doubled from $2.6 billion to $5.3 billion in FY15 to comprise 6.7 percent of the 2015 budget, more than what the City pays for police salaries.

CBC called for negotiating changes to health insurance as part of collective bargaining and was pleased when Mayor de Blasio announced a Health Savings Agreement with the first contract settlement. The City and the MLC agreed to save $3.4 billion through FY18, with savings to recur in FY 2019 and thereafter and an independent actuary would be selected to verify the potential savings; 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 agreements. In June 2014, CBC President Carol Kellermann wrote to the Labor Commissioner, Bob Linn, to suggest guidelines for identifying initiatives and quantifying savings; 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 enrollee utilization of services, better managing chronic conditions or lowering provider payments; 2. Savings should be counted clearly and honestly, lower national and regional health care inflation, temporary premium 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 cost curve when it comes to rapidly increasing health care costs," which he affirmed today again in his testimony. However, some of the initiatives that he cited, which he also mentioned today, would offer only one-time or temporary savings, such as premium rate caps and

relief from the mental health parody payments. In addition, he stated that all savings will be calculated relative to the financial plan projections rather than actual results from specific initiatives; thereby divorcing any savings claimed from changes in the benefit structure of the health insurance program.

Prior to this hearing there had been no public report of savings attributable to specific initiatives and as the Chair noted, the November modification of the budget gave credit to the MLC agreement for $1.3 billion in savings, from lower than anticipated premium increases from the employee and retiree health insurance plans. As a result, savings that would have normally been reserved for general budget needs, such as funding libraries or maintaining public parks 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 agreement could

equal $2.5 billion of the $3.4 billion 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 plan; many of the initiatives he described today, such as reducing emergency room utilization, improving chronic care disease management and cost containment for specialty drugs, 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. Thank you.

SHERRY GLIED: Hi. I'm Sherry Glied; I'm the Dean of the Wagner School at NYU and I'm a health care economist. Thank you, Chairwoman Ferreras and Committee members for inviting me to speak. I'm gonna try and give you a general picture of how health care costs work so that that might help you reconcile some of the things that you've been hearing, so let's start at, you know, 50,000 feet level.

Across all countries over time, health care cost growth has historically out-paced the rate of economic growth; that's happened for decades; the primary reason for that is improvements in health care technology, which unlike in other sectors of the economy, tend to lead to increases in expenditure because the market grows as we come up with new ways to cure people.

Over the last five or eight years the rate of technological change in health care has slowed somewhat, probably in part because of the recession; that looks like it's coming back, especially in the pharmacy arena.

If you move down from sort of looking at the globe as a whole and look at the nation only, looking within a country over time, economic conditions are an extremely important predictor of health care spending. Economic conditions affect spending for several reasons; first of all, most health plans, most employer plans require employees to pay premiums and during recessions that often leaves people to drop their health coverage altogether; second, most health plans require people to pay co-payments; during recessions when people

have less money they are less likely to use services if they have co-payments, and some people put off elective services when unemployment rates are high 'cause they don't wanna take time off work and risk losing their jobs.

Since 2008, worldwide, as the great recession hit all of the countries of the developed world, health care spending growth slowed dramatically. Between 2008 and 2012, across all the high-income countries that we look at, health care spending averaged just 2.8 percent a year, so very, very slow and in the U.S. we were very slightly above that, about 2.9 percent a year. That slow rate of increase in health care spending has been an enormous boon to public budgets at the national level, at the state level and at the city level. So there has been this enormous decline in health care spending because of economic changes; it's also been a benefit to employers because employer premium growth has been about half of historic levels.

If we look across localities at the same time, local health care costs can also be affected by changes in local health care markets, and a growing body of evidence suggests that reduced competition in

health care markets can be a real problem for employer plans. Currently many cities; many states are trying to actually increase integration and system coordination across plans; there's a big debate in the health care economics literature about whether that's going to lead to savings or it's actually gonna lead to increases in cost as competition is reduced. So that will affect all the private insurance plans in a given market.

And finally, at the level of a specific health plan there are a number of very well understood steps that can be taken to reduce employer costs, and we could think about these in terms of robustness and the evidence for reducing cost. One way is to increase the employee's share of premium payments; that very clearly reduces cost to the employer. As second cost-control practice about which we know a lot is raising cost-sharing, paying a larger share of each health care bill leads enrollees to use fewer services. Over time the basic strategy of raising cost-sharing generally has been modified and so plans now do what's called value-based cost-sharing where some drugs and services have lower cost-sharing than others, like the example of lower

cost-sharing for primary care visits than for the emergency room.

There is also opportunities to combine cost-sharing with tax-preferred plans, like health savings accounts and new ideas; CalPERS has a model where cost-sharing varies depending on the expense of the provider that you use, what's called a tiered network plan.

A third strategy for reducing cost is to limit and control the network of providers that's available to patients; by doing that, insurance companies can negotiate lower fees with providers; that is the main way that they can reduce the fees that they pay to providers and also, to some extent, improve the quality of services that they offer.

And finally, there's a range of cost-reduction strategies that involve wellness, health promotion, case management of high-cost cases, and the goal of these strategies is both to improve the underlying health of the population and reduce their subsequent health care costs. I would have to say that the evidence of their effectiveness in terms of cost-control is pretty mixed; we don't know very much yet.

As you think about strategies for reducing health care costs for New York City employees, I think it's important to focus on the strategies that work at the level of the individual health plan; the City has clearly no control over the global development of technologies, which leads to long-term growth of health care; doesn't have much control over the timing of recessions, unfortunately, which can also affect health care cost growth. New York City government employees are just not a large enough share of the market to affect the way that the whole New York City health care system becomes integrated or competitive, so I think the most important thing is to focus on what happens at the level of the health plan. Over the recent past, these global national and local factors have reduced the rate of health care spending growth in New York City, but it is unlikely that they will persist indefinitely. Thank you.

CO-CHAIRPERSON FERRERAS: Thank you for your testimony and thank you both for bringing your expertise; I know that the presentation earlier was very long and we're usually here a long time, but that one was exceptionally long, so I thank you for

your patience [background comment] and maybe Dr. Majewski could take you to lunch or something. [laughter][background comments] Yes; actually, we're going into budget negotiations right after this, in like a couple of minutes.

But I wanted to -- I have two questions. Professor, what best practices should the City consider regarding the use of ACOs; are you aware of any pilot projects elsewhere that we might want to keep in mind, moving ahead?

SHERRY GLIED: So the federal government and a number of states, including New York State actually, in its Medicaid program, have been working on models for trying to contain cost through better integrated care and there's actually a lot of evidence coming out of the federal efforts to do it; there's some evidence out of Massachusetts. So there is some evidence that carefully designed programs to integrate care and really focus resources on the highest cost cases can lead to savings. I wouldn't say that the evidence is incredibly firm, but you know, in an area where we're really trying everything that we possibly can, I think that is one of the directions that looks most promising.

CO-CHAIRPERSON FERRERAS: Thank you. And Maria; have you seen indications that the City is creating an objective system of measuring the impacts of its health care savings plan; what are the most significant two or three indications?

MARIA DOULIS: Well we have a concern that the savings are being measured against what's projected in the financial plan and not relative to changes -- rather, not relative to the results of specific changes being made, and so they are able to claim credit from a reduction in the premium even thought that does nothing to change the consumption of health care or the cost of health care delivery. So what we are advocating for is changes that will establish a baseline based on prior utilization and cost of service, project that out and then based on whatever changes are agreed to with the union, calculate the savings against that baseline, and in my testimony packet I've included an example where we sort of -- a hypothetical example that illustrates how that would be done.

CO-CHAIRPERSON FERRERAS: Thank you. And I have one more question; I'm gonna give it to Chair Miller. Uhm… sorry. Is there anything… I'm sorry.

The City covers the lion's share of the premium cost for public workforce; Professor, is this unusual and how common is it, in your experience, for employees of a major employer to cover part of their individual and family premium costs?

SHERRY GLIED: So over time that -- you know, maybe 25, 30 years ago it was very common for large employers to cover the full cost of single premiums; family premiums, historically, almost nobody covered full cost of family premiums; over time there has been a shift and relatively few large employers continue to cover the full cost of even single premiums and in general, cost-sharing for family premiums has been going up, and the reason for that is that employers want, for example, in two-earner families, for the spouse to take the coverage offered by say his employer and not the employee's employer; right, so instead of covering your husband under your own plan, have him get covered under his plan.

CO-CHAIRPERSON FERRERAS: So is that to discourage a double-insured?

SHERRY GLIED: Or just to keep the cost off of that employer, so rather than having… you

know, so let his company cover his cost and your company cover your cost. So for example, many universities have a three-tiered system where an employer and children can be covered at much less cost than an employer and a spouse and children, [background comment] 'cause the expectation is that the spouse will then go off and get coverage from his or her own employer and save the university money… [crosstalk]

CO-CHAIRPERSON FERRERAS: 'Cause it's always been our understanding, and at least our experience, for example, I'm insured, my fiancé's insured; we have our son on both of our insurances; we're paying everything, so what incentivizes, or you know; is that the right thing to do, from your perspective, right for a family, 'cause we always wanna make sure that we're covered; the panic is that god forbid something happens and you're not covered.

SHERRY GLIED: Right. So I would say a couple of things in that respect. So one is, probably it doesn't make sense to cover your son under both of your policies, [laughter] just in terms of your own… [interpose]

CO-CHAIRPERSON FERRERAS: See I'm getting advice already. Yes, thank you.

SHERRY GLIED: your own plans, is that, you know basically employers are trying to discourage that kind of behavior, 'cause they don't wanna be charged double for those services and I think that one of the… I mean one of the things that we could look to is that with the Affordable Care Act implementation it's a little bit less risky to be in a situation where you worry that one of you might lose your coverage and then not have anywhere to do, so in some respects I think that that push to try and get people onto their own employer coverage, and also with the employer mandate, which is requiring more employers to be offering that coverage, you could be doing a little bit more to shift coverage to employees.

CO-CHAIRPERSON FERRERAS: Thank you. Chair Miller.

CHAIRPERSON MILLER: Thank you, Chair. So is it safe to say that a lot of the savings that has been achieved that we've been seeing nationally and locally is attributed to Affordable Care?

SHERRY GLIED: Well we don't know whether it's attributable to the Affordable Care Act itself, but it's certainly attributable to changes in national trends; that's one of the contributions to national trends, the recession is another contribution to national trends; there's a lot of work trying to sort out which of those things is, but a lot of it is just a national trend.

CHAIRPERSON MILLER: So how much of this do you anticipate, based on your expertise, do you expect to continue in, say over the life of this agreement?

SHERRY GLIED: So predicting the future is something I'm not really very good at; I do think it would be fiscally wise to be thinking through what are the savings that are related to the agreement and what are the savings that are attributable to things that are happening outside the bounds of the agreement. And I think that's a separate question than actually trying to make a prediction of health care cost growth, which is a touch thing to do; certainly people were wrong 10 years ago, but I think there are ways to do that; I think there are ways to assess how much savings are you actually achieving

through this agreement itself; that it's separate from what's happening to national cost growth.

CHAIRPERSON MILLER: So as we talked about kind of opting out of a health plan or families having multiple health plans and when you have insufficient health care, then it sometimes becomes necessary to have the backup, and in the case where you have a sufficient plan -- and did you hear my question earlier to the Administration about their opt out plan or their payout to the opt out plan; do you see that as a viable -- it… [interpose]

SHERRY GLIED: That's sort of a different way of achieving the same thing.

CHAIRPERSON MILLER: So it exists right now…

SHERRY GLIED: Sort of exists in that way; it's a different way of achieving the same outcome.

CHAIRPERSON MILLER: So it exists now and they pay $1,000 per year to a family that… [interpose]

SHERRY GLIED: Right.

CHAIRPERSON MILLER: decides to opt out.

SHERRY GLIED: Right. So that's just a different way of classifying the same thing; I don't know relative to their health plan coverage… [crosstalk]

CHAIRPERSON MILLER: But they're not attracting enough families… [crosstalk]

SHERRY GLIED: Right.

CHAIRPERSON MILLER: to opt out that can opt out, according to their audit… [interpose]

SHERRY GLIED: Right.

CHAIRPERSON MILLER: right? My suggestion would be to offer a significantly higher -- it still would attain a significant savings if they did so.

SHERRY GLIED: So there are different ways that you could structure that and I think there might be ways to be able to encourage more people… [crosstalk]

CHAIRPERSON MILLER: So also, and this goes to both of the panel members there; it was kind of what is trending in terms of how health care is delivered and who pays and… or some portion of it; taking into consideration that this is part of the overall compensation package, we have to, you know,

take that into consideration that they may be taking a little less because they inherently have this along a pension or whatever and so what trends nationally or in certain areas, and particularly that it's well-known that often public employees had less of a monetary impact because of the deferred compensation, including benefits and pension and so forth as we move forward; any opinion on that?

MARIA DOULIS: I think that's right; I think you wanna be looking at the total compensation package and prior to this plan; I mean, pensions are protected constitutionally and they're not negotiable at the local level, but health insurance and salaries and wages were not looked at together, so they do deserve credit for kind of putting that in a package deal as they negotiate the labor settlements. You know I would say that, as the Dean said here, you know, the most predictable way to get the savings is to do a little bit on the premium and share that with employees, and even if you did a de minimis amount -- 5 percent, 10 percent; something well below the national average of up to 25 percent, you could see a significant savings there that wouldn't really hurt employees very much.

CHAIRPERSON MILLER: [background comment] Have you seen this locally or do you see where… [crosstalk]

MARIA DOULIS: We did a study that looked at large public cities, state government; federal government and assessed the level of premium-sharing and compared it to the City and the City was the only public employer even; private sector is way ahead, in terms of the share required for the premium on average, but the City is the only public employer that we found in our study that covered 100 percent of the premium cost for both single and family coverage, as well as for retiree coverage for early retirees.

CHAIRPERSON MILLER: So there are other local municipalities and authorities that have employee health care contributions, obviously, but there are… and but relatively significant to what you're talking about, less than national average, but relatively significant and what I find is, you know unless you kinda access and research the entire agreement, that they are paying for -- say for instance they were paying a portion of their salary and whether it's one, two; three percent, but there

are other things that are being provided by the City outside of this specific benefit package, whether it be long-term health insurance and/or prescription drug, they're paying for prescription drugs, a monthly premium here, which those other plans do not require, so in some ways they're already paying for a portion of the benefit that is being delivered by those other municipalities and, even local authorities, so I think that's something that we have to take into consideration; something that I will consider whether or not it's more prudent to pay for prescription drugs which you control and/or whether or not you are paying for a portion of the general medical. And so I think that we have to consider that, you know, because I think that the notion here is that there is no employee contribution across the board and that is incorrect, but is it placed where it should be placed where you're getting the most bang for your buck; I think which is the theme of this entire hearing here; how do we get the most bang for our buck? So thanks.

[background comment]

CO-CHAIRPERSON FERRERAS: Thank you, Chair Miller. Professor, I just wanted to follow up

with something you said. How should the City try to distinguish between the two causes of changes in health care costs?

SHERRY GLIED: So there's actually -- I think the way to -- I think there are different ways to do it, but one way -- there are at last a couple of different ways here; one is to compare what's happened to health care cost in the City to widely available data on what's happened to health care costs nationally and to large employers; you can get data on large employers in the northeast and all kinds of other metrics, so you could actually compare it in real time with what's going on. And a second way to do it, which I think they have done some of it in the presentation this morning, is to focus on individual programs and to say how much savings do we anticipate getting out of this program; this is a program that does X, Y and Z and so from this program we anticipate getting so much savings, and that's -- I mean there you really have a clear tie between what they're doing and where the money is coming from.

CO-CHAIRPERSON FERRERAS: Great. Thank you. I think [background comment] we're done. Thank you so much for your testimony; if we have any

follow-up questions we'll give you a call; I would really appreciate it. Thank you again. Thank you to the Committee, both Committee counsels, both Committee analysts, to our Finance Division; this was a hearing that was very thoughtful and also we wanted to get the details that we got, but we will be following up with the Administration. Thank you all for coming; I call this hearing to adjourn.

[gavel]

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 April 22, 2015