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November 29, 2018

Oversight: Healthcare Savings Agreement: A Look Back and a Look Forward

I. Summary

Today, the Committee on Finance, chaired by Council Member Daniel Dromm, and the Committee on Civil Service and Labor, chaired by Council Member I. Daneek Miller, will jointly hold an oversight hearing on the health care savings agreements entered into by the City of New York and the Municipal Labor Committee ("MLC"), an association of municipal labor organizations dedicated to collectively addressing concerns common to its member unions.

On June 16, 2018 the administration of Mayor Bill de Blasio ("Administration") and the MLC announced a new commitment to generate substantial employee healthcare cost savings totaling $1.1 billion over three fiscal years (2019-2021). The June 2018 agreement ("the 2018 agreement" or "the 2018 savings plan") follows a previous agreement dating back to May 2014 ("the 2014 agreement" or "the 2014 savings plan"), in which the Administration and the MLC announced – and reportedly subsequently reached – a target of $3.4 billion in savings over four years, starting with $400 million saved in Fiscal 2015 and growing to $1.3 billion saved in Fiscal 2018.

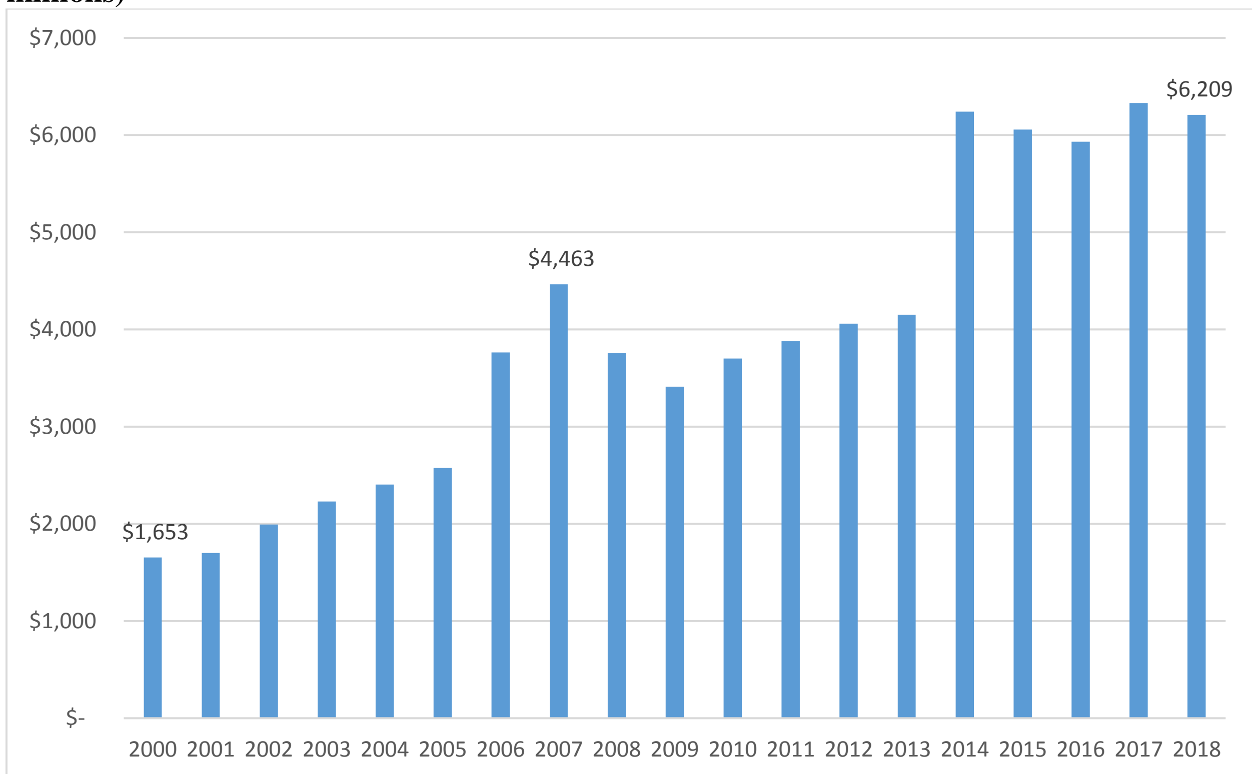
Today's hearing will provide an initial look into the 2018 savings plan – its key features and effects on the workforce and the City's finances – as well as an opportunity for an update on the final accounting and summary of the 2014 agreement. In addition, with an interest in better understanding the health insurance market for the City of New York, the Committees look forward to discussion of the overall health insurance landscape in New York and the specifics of premium rate setting in New York by insurance companies who operate in a highly concentrated market.

Representatives from the New York City Office of Labor Relations, the New York City Office of Management and Budget (OMB), and other interested parties were invited to testify.

II. The Bigger Battle – Health Insurance Premiums

Health insurance represents a considerable cost for the City, and has grown substantially over time, as shown in Figure 1. In 2000, the City spent over $1.6 billion on health insurance for its employees. By 2017, this cost had risen to over $6.3 billion, and dropped slightly to $6.2 billion in Fiscal 2018.[1] A significant portion of these costs is attributable to the premiums paid by the City to the health insurance companies for employee coverage.

Figure 1: Total Cost of Health Insurance for City Employees, Dependents, and Retirees ($ millions)

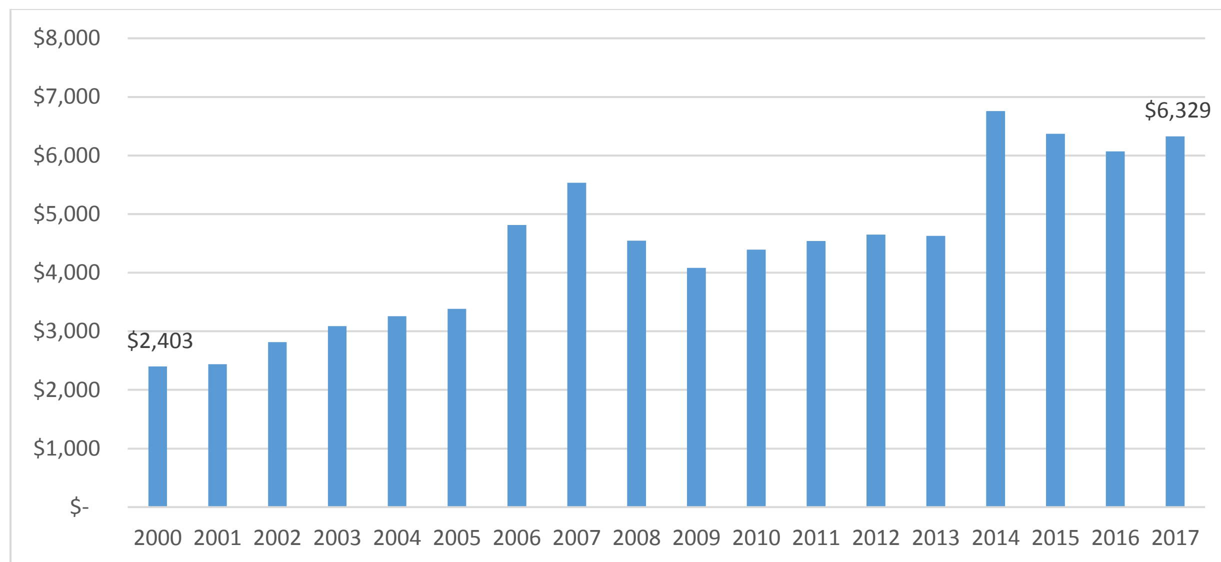


Source: Comprehensive Annual Financial Reports of the Comptroller (Fiscal Years 2001-2018)

Even adjusting for inflation, the growth in total health insurance expenditures has been impressive, growing 163 percent since Fiscal 2000, as shown in Figure 2 below.

[1] The projected cost for the current fiscal year according to the Fiscal 2019 Adopted Plan is $6.6 billion.

Figure 2: Total Cost of Health Insurance for City Employees, Dependents, and Retirees (Real, 2017=100, $ millions)



Source: Comprehensive Annual Financial Reports of the Comptroller (Fiscal Years 2001-2017). Adjustments made using Implicit NYC GDP Deflator

The City offers three insurance plans to all employees and retirees at no cost for basic coverage (prescription drug, dental, and other benefits can be purchased through additional riders or are often provided through employees' welfare funds). These three plans are Group Health Insurance – Comprehensive Benefits Plan ("GHI-CBP"), a preferred provider plan; Health Insurance Program of NY ("HIP"), a health maintenance organization ("HMO"); and most recently MetroPlus Gold, an HMO. According to the Independent Budget Office, there were nearly 423,300 separate health contracts covering full- and part-time City employees, retirees, and their families as of December 31, 2017.[2] In 2017, even though there were 12 plans offered to eligible City employees, 96 percent of employees were enrolled in GHI-CBP, HIP, or MetroPlus Gold.[3] The

[2] "Could City Employees Provide a Major Source of Enrollees for Metroplus Gold?" New York City Independent Budget Office. July 2, 2018. https://ibo.nyc.ny.us/cgi-park2/2018/07/could-city-employees-provide-a-reliable-source-of-enrollees-for-metroplus-gold/

[3] Id.

price of health insurance, as measured by premiums, has been going up. In Fiscal 2018, the annual HIP premium paid by the City was $8,166 for individual coverage and $20,008 for family coverage, up 118 percent since Fiscal 2007. As for GHI, the annual premium in Fiscal 2018 was $7,479 for individual coverage and $19,604 for family coverage, up 104 percent since Fiscal 2007.[4]

Coincident with the considerable increase in the cost of health insurance, concentration in the health insurance market has also increased over the last decade. According to a 2017 update to the American Medical Association's "Competition in Health Insurance: A Comprehensive Study of US Markets," 69 percent, or 270 out of 389 Metropolitan Statistical Areas in the US, are highly concentrated.[5] Concentration increases the chances that firms can use their market power to increase prices and reduce services in ways that are good for their profits but hurt buyers and users of their services.[6] Considering this concentration, understanding how premium rates are set is crucial in understanding the overall cost of health insurance to the City, and the level of benefits being afforded to its municipal workforce.

When the City's two main insurers, HIP and GHI, merged in 2006 under Emblem Health, the City sued arguing: "If the merger were allowed to take effect, the newly formed company would control more than 90 percent of the City's municipal health care market and 100 percent of the 'low-cost' municipal market, resulting in substantially higher premiums at astronomical costs to the City."[7] Despite the City's concern, the merger was allowed to take effect.

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[4] See Fiscal 2001 through 2018 Comprehensive Annual Financial Reports of the Comptroller, available at: https://comptroller.nyc.gov/reports/comprehensive-annual-financial-reports/ (last accessed October 18, 2018). 2018 premium amounts made available to Council Finance staff by the NYC Office of Management and Budget

[5] "Competition in Health Insurance: A Comprehensive Study of US Markets, 2017 Update." American Medical Association. https://www.ama-assn.org/about/competition-health-insurance-research

[6] Stigler, G. L 1964 "A Theory of Oligopoly" *Journal of Political Economy, 72, 44-61*

[7] See New York City Law Department, Office of the Corporation Council, "Press Release: New York City Sues HIP and GHI Seeking to Enjoin the Two Health Insurance Companies from Merging."

Insurance in New York State, including the premium rates charged by health insurance companies, is regulated by the New York State Department of Financial Services ("DFS"). Pursuant to New York State's "prior approval" law, many health insurers must request approval of premium rate increases before they make adjustments.[8] The federal Affordable Care Act required the issuance of community-rated plans and for states to create rate review over such plans. In 2010, New York State enacted Chapter 107 of the Laws of 2010, which granted the Department of Financial Services (DFS) authority to approve, disapprove, or modify community-rated policies issued by commercial health insurers (both for-profit and not-for-profit) and HMOs in New York State. Prior approval does not apply to experience-rated large group policies or self-insured plans.[9]

DFS reviews each health insurer's requests and has the authority to review the actuarial assumptions behind their proposed rates and the financial condition of the insurer to make certain the proposed rates are fair and appropriate. DFS can approve, reject, or modify the proposed rates. There are a number of considerations DFS makes when reviewing an insurer's request for a premium rate increase. It is important to note that the review process is different depending on the specific insurer and the specific product. Important factors include past claims experience under the specific policy at hand; utilization of services; the insurer's history of rate changes, its financial

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[8] See "Health Insurance Rate Review (Prior Approval) Consumer FAQs." New York State Department of Financial Services, April 4, 2016, available at https://www.dfs.ny.gov/consumer/health_ins_prem_faqs.htm (last accessed October 18, 2018).

[9] Under community rating, an insurer charges all people covered by the same type of health insurance policy the same premium without regard to age, gender, health status, occupation, or other factors. The insurer determines the premium based on the health and demographic profile of the geographic region or the total population covered under a particular policy that it insures. In comparison, an insurer uses experience rating when it predicts a group's future medical costs based on its past experience (i.e., the actual cost of providing health care coverage to the group during a given period of time; the group's claim history). Thus, the insurer calculates the group's insurance premium based on its own, not the overall community's, experience. See Kaminski Leduc (2008. July 3) *Community Versus Experience Rating Health Insurance.* https://www.cga.ct.gov/2008/rpt/2008-R-0377.htm

condition, administrative costs, profits, and other sources of revenue; and other factors the insurer uses to calculate its proposed premium increase.

As part of DFS's review process, the City is permitted to submit comments regarding HIP's requests for rate increases. In its comments to HIP's rate increase request in 2015, the Commissioner of the City's Office of Labor Relations ("OLR") requested "that [DFS] find HIP's proposed rate increase unwarranted …" Among the reasons cited:

- "The increase is not justified by financial need and in fact, HIP/Emblem Health should be reducing its surpluses;"[10]
- "Emblem Health is unfairly using its profits at HIP to cross-subsidize less profitable companies under its umbrella;"
- "Emblem Health describes worryingly high administrative costs including aggressive rates of executive pay that have been the subject of DFS concern in the past;" and
- "Emblem Health is relying on highly conservative estimates that seem calculated to produce profits, rather than reflect the accurate economic conditions the company faces."[11]

Despite the City's objections, the increase was approved. Since, 2015, the City has not submitted comments with respect to requested rate increases.

III. The 2014 Savings Plan

A. Background

In an effort to stem the rising healthcare costs described above, the City and the MLC developed a healthcare savings agreement as part of the collective bargaining agreements. When Mayor de Blasio and the United Federation of Teachers announced a deal in May 2014 that established a pattern for collective bargaining agreements, the cost of settling all contracts came to a hefty $14 billion – thereby requiring a method to spread out that cost, as well as additional

[10] Insurance company surpluses are essentially retained profits that give the company a financial cushion.
[11] New York City Office of Labor Relations, Letter to Anthony J. Albanese Superintendent of Financial Services New York State Department of Financial Services, Re Health Insurance Plan of Greater New York" September 18, 2015.

savings wherever they could be found. Ultimately, OLR and union leaders agreed to work together and created a process that was intended to produce cumulative healthcare savings of at least $3.4 billion over four fiscal years, Fiscal 2015 through Fiscal 2018. Specifically, the parties agreed that the following amounts would be saved in each of the subsequent fiscal years:

- $400 million in Fiscal 2015;
- $700 million in Fiscal 2016;
- $1 billion in Fiscal 2017; and
- $1.3 billion in Fiscal 2018.

Pursuant to the agreement, the structural changes producing those savings would remain in place beyond the four-year plan. In addition, the agreement stipulated that if the savings were to exceed the $3.4 billion minimum, the first $365 million of excess savings would go back to the workforce as a bonus payment, while additional savings beyond that would be split between the City and the workforce. The two sides also announced a $1 billion transfer from the Health Insurance Premium Stabilization Fund ("HISF"), a fund jointly controlled by the City and the MLC, to help cover the labor agreements' expected cost. It should be noted that the purpose of the HISF, primarily funded from City taxpayers, is to prevent City employees from having to pay part of their premium out of pocket by requiring the City to pay the difference between the cheaper and more expensive medical plans offered.

Lastly, the 2014 savings agreement stipulated that at the conclusion of the agreement in Fiscal 2018, there would be a final calculation of the savings realized, and that in the event that more than $3.4 billion was achieved, the first $365 million would be credited proportionately to

each union as a one-time lump sum bonus payment for its members. Additionally, any savings over the first $365 million would be split equally between the City and the MLC.[12]

B. Progress and Reporting

In order to achieve savings, a number of different initiatives were agreed upon by the OLR and the MLC and have been detailed by OLR in quarterly reports.[13] According to OLR, the savings targets for Fiscal 2015 and 2016 were met and the targets for Fiscal 2017 and 2018were met and exceeded.[14] In its "Final Report on the Fiscal Years 2015 – 2018 Savings Program and Fiscal Year End 2018 Healthcare Savings Report," OLR reported that a savings of $1.051 billion was achieved in Fiscal 2017, generating a surplus of $51 million over the savings target for that year. As for Fiscal 2018, savings of $1.335 billion were achieved, exceeding the $1.3 billion goal by $35 million.[15]

More than half of the savings from the 2014 savings agreement came in the form of lower-than-anticipated premium rate increases at both of the two health insurance plans most commonly used by City employees, HIP and GHI-CBP. As Figures 3 and 4 show below, over $1.9 billion in savings (or roughly 55 percent of the $3.4 billion total saved under the plan) was attributed to rate increases that were lower-than-forecasted in the City's budget.[16]

[12] Health Benefits Agreement Fiscal Years FY2015-2018. See Section 5. NYC Office of Labor Relations. https://www1.nyc.gov/assets/olr/downloads/pdf/collectivebargaining/health-benefits-agreement-fiscal-years-2015-2018.pdf
[13] See Related Links. NYC Office of Labor Relations. https://www1.nyc.gov/site/olr/labor/labor-health-savings.page (last accessed October 16, 2018).
[14] "Final Report on the Fiscal Years 2015 – 2018 Savings Program and Fiscal Year End 2018 Healthcare Savings Report." NYC Office of Labor Relations, available at https://www1.nyc.gov/assets/olr/downloads/pdf/collectivebargaining/final-report-fy-2015-2018-savings-fy-2018-healthcare-savings-report.pdf(last accessed October 24, 2018)
[15] Id.
[16] Id.

Figure 3: Annual HIP Rate Increases and Associated Savings ($ millions)

Actual HIP Rate Increase (assumed 9%)	2015	2016	2017	2018	Total Savings
2.89% in FY16	17	335	367	401	1,120
5.98% in FY17		8	173	190	371
7.84% in FY18			3	70	73
6.84% in FY19				1	1
Total					**$1,565**

Figure 4: Annual GHI Senior Care Rate Increases and Associated Savings ($ millions)

Actual GHI Senior Care Rate Increase (assumed 8%)	2015	2016	2017	2018	Total Savings
0.32% in FY15	38	42	46	50	176
(0.07%) in FY16		35	39	43	117
4.73% in FY17			15	16	31
2.42% in FY18				26	26
Total					**$350**

It should be noted that the Final Report places considerable emphasis on the use of economic incentives to encourage the appropriate use of healthcare. Copays were increased in some areas while decreased in others in an effort to affect utilization – something which has resulted in savings, as noted in the description of other savings set forth below. According to the report, "emergency room utilization decreased by about 11.2 percent, urgent care visits decreased by 10.9 percent, and diagnostic X-ray and lab tests decreased by 10.1 percent."[17]

At face value, such reductions in utilization may appear worthy of praise. But it is difficult to determine whether those impacted by this agreement have actually over-utilized services in the first place. Nationally, the United States is far below the utilization of physicians and hospitals among other countries that are part of the Organisation for Economic Co-operation and

[17] See, Final Report, supra, fn. 14.

Development.[18,19] Additionally, it is possible that the workforce will cut back on other forms of care, including care that could actually be cost saving in the long run. Utilization by the City workforce may continue to go down, but prices will likely continue to increase. In this sense, the Committees are more interested in efforts to control prices, not use.

Nevertheless, beyond the savings from lower-than-forecasted premiums, roughly $1.37 billion in savings over the four years came from six initiatives, representing 39 percent of the total savings, outlined briefly below.[20]

1. Dependent Eligibility Verification Audit (DEVA): $443 million in savings.

The DEVA program – an audit of dependent eligibility for coverage – resulted in conversions of family to individual health contracts. This provides continued savings from lower health premiums.

2. Funding Structure Change in the City's GHI Plan: $211 million in savings.

The funding structure change in Fiscal 2015 from a fully insured plan to a minimum premium plan arrangement resulting in lower administrative expenses and positive tax implications.

3. GHI-CBP Program Changes: $193 million in savings.

Effective July 1, 2016, changes were made to the GHI CBP program that address the underutilization of primary and preventive care and the overutilization of emergency room, specialty and other care.

4. Mental Health Parity "Relief": $148 million in savings.

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[18] The Organisation for Economic Co-operation and Development is an intergovernmental economic organization with 36 member countries, founded in 1961 to stimulate economic progress and world trade

[19] Bivens, Josh. "The Unfinished Business of Health Reform: Reigning in market power to restrain costs without sacrificing quality or access." Economic Policy Institute. Pg 47. October 10, 2018. https://www.epi.org/files/pdf/152676.pdf

[20] The remaining six percent of savings (roughly $204 million over the four years), came from smaller initiatives and programs which will not be discussed in this report. For descriptions of each of the initiatives from the 2014 Savings Plan. See, Final Report, supra, fn. 14.

Federal mental health parity regulations required that mental health benefits be equal to medical benefits. The last administration contended that the cost of health plan compliance with this be borne by the HISF. The issue was arbitrated and in late 2014 it was ruled that the City had to reimburse the Stabilization Fund for mental health benefit costs covered by the fund during 2011-2015. However, the MLC agreed that the City could forego the refund in favor of using that money to meet part of the Fiscal 2015 healthcare savings obligation.

5. HIP HMO Preferred Plan: $135 million in savings.

The transition from the HIP HMO Plan to the HIP HMO Preferred Plan, effective July 1, 2016, reduced the overall cost to the City for employees and pre-Medicare retirees enrolled in the program and lowers the benchmark HIP rate that drives the payment for their coverage. The City is obligated to make an equalization payment into the HISF that makes up the difference between the HIP HMO rate and the GHI-CBP rate. The HIP HMO Preferred Plan lowers the benchmark HIP rate, and thereby lowers the City's obligation to the HISF.

6. Changes to Care Management Program: $117 million in savings.

In March/April 2015, the existing pre-authorization program was expanded. The previously limited case management program was amplified to include case management for all complex and high-cost acute and chronic conditions, as well as maternity management and readmission management programs. In January 2016, a new vendor was selected to administer the programs and to implement new pre-authorization requirements for outpatient procedures.

7. Specialty Drugs (PICA) Program Changes: $120 million in savings.

The contract for the specialty drug program was renegotiated several times during the past few years and is generating savings from improved pricing and certain cost management provisions such as pre-authorization and drug quantity management programs.

IV. The 2018 Savings Plan

The second health care savings agreement intends to find savings of $200 million in Fiscal 2019, $300 million in Fiscal 2020, $600 million in Fiscal 2021, and $600 million annually thereafter.[21] According to the Administration, savings will be measured against the City's projected budget increases of seven percent, 6.5 percent, and six percent for Fiscal 2019, 2020, and 2021, respectively.[22] Among other initiatives, OLR reports on its website that savings will be achieved through a series of measures including a cap of City healthcare increases of 3.5 percent in Fiscal 2020 and three percent in Fiscal 2021.[23] However, there is no language regarding this cap in the healthcare savings agreement itself and, to date, no public explanations have been offered by the Administration. Therefore, it is unclear exactly what this cap is or how it will be implemented.

The 2018 agreement also requires the quarterly provision of data from EmblemHealth and Empire Blue Cross to the City's and MLC's actuaries.[24] According to the 2018 agreement, EmblemHealth and Empire Blue Cross will provide detailed claim-level data for City employees covered under the GHI-CBP programs as well as utilization data under the HIP-HMO plan. The utilization data will include utilization by procedure for site of service benefit changes; utilization by disease state, by procedure; and member engagement data for the Wellness program.

Despite the agreement in the 2014 savings plan that excess savings be credited proportionately to each union as a one-time lump-sum bonus payment for its members, in the 2018

[21] See "Health Benefits Agreement Fiscal Years 2019-2021." NYC Office of Labor Relations. June 28, 2018, available at: https://www1.nyc.gov/assets/olr/downloads/pdf/collectivebargaining/health-benefits-agreement-fiscal-years-2019-2021.pdf (last accessed October 18, 2018).
[22] Id.
[23] See https://www1.nyc.gov/site/olr/labor/labor-health-savings.page (last accessed October 18, 2018).
[24]See "Health Benefits Agreement Fiscal Years 2019-2021," supra fn. 21.

savings plan, the City and the MLC agreed that any savings above the 2014 Savings Plan target of $3.4 billion can be used to count towards the Fiscal 2019 goal.[25] Additionally, any recurring savings above the $1.3 billion for Fiscal 2018 from the 2014 savings plan will count towards the goal for Fiscal 2019, 2020, and 2021.[26] According to the OLR's Final Report however, the total savings of the entire 2014 Savings Plan amounts to $86 million. After the conclusion of Fiscal 2021, the MLC and the City will calculate the total savings realized during the period and if more than $600 million is generated in recurring healthcare savings, the first $68 million will be used to make a $100 per member per year increase to the welfare funds.[27] The 2018 savings plan also includes two $100 per member one-time lump-sum payments to the welfare funds, funded by the HISF, payable effective July 1, 2018 and July 1, 2019.[28] However, with the savings from the 2014 savings agreement being rolled over towards the Fiscal 2019 target, rather than being appropriated as a one-time lump sum bonus payment as originally agreed in the 2014 agreement, it is unclear how the new one-time lump sum payment in the 2018 savings agreement is being funded.

The City and the MLC also agreed to form a Tripartite Health Insurance Policy Committee consisting of MLC and City members as well as Martin F. Scheinman, Esq., the jointly designated arbitrator for disputes regarding the agreement, to study the longer-term sustainability of health care for workers and their families.[29] Topics to be studied relate mostly to health care service delivery, and include consolidated drug purchasing, potential requests for proposals for all medical and hospital benefits, and the status of the HISF.[30]

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[25] Id.
[26] Id.
[27] Id.
[28] Id.
[29] Id.
[30] Id.

VI. Previous Council Oversight

Today's hearing will mark the third oversight hearing of the jointly identified health care savings agreements between the Administration and its workforce. The first hearing took place on April 1, 2015 and included testimony from representatives of OLR, the Office of Management and Budget, the Citizens Budget Commission, and the Wagner School at New York University.[31] The second hearing took place on February 26, 2016 and included testimony from representatives of OLR, the Office of Management and Budget, the Citizens Budget Commission, and the Independent Budget Office.[32]

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[31] Oversight – Examining Health Care Savings Under Recent Collective Bargaining Agreements. Committee report and transcript available at https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2244418&GUID=2C26971C-EE8A-44C9-B4A6-1BAC51C46255&Options=&Search=

[32] Oversight – Update on Health Care Savings Under the City's Collective Bargaining Agreements. Committee report, testimony, and transcript available at https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2565150&GUID=68B4035D-7520-4940-914E-1622FEB5F001&Options=&Search=