# Healthcare Matters

The quality and cost of healthcare for our in-service and retired members and their dependents is of vital importance, affecting both their health and their pockets. Keeping both of those concerns in focus and in balance has been a longstanding goal of the MLC. These matters are complex. That is why, at this critical moment, we need to remember where we have come from and what we have already accomplished to help guide us to arrive at what we still need to do going forward.

The cost of healthcare has increased exponentially, more than doubling over the past 10 years in particular, during which hospital costs outpaced medical by a significant margin. While some view healthcare benefits and other forms of compensation separately, employers, including the City, have come to regard pay and benefits as a package, with consideration to the cost of each component. Stated simply, increased employer expense on healthcare negatively influences the ability to maintain quality benefits and impacts union bargaining goals to secure desired increases in wages.

That said, the MLC and the City have recognized that increases in the cost of health benefits are not always driven by improvements in benefits. Outside pressures and actors play a role. Increased costs can result from inefficiencies, changes to provider structure or policy or the efforts of some service providers – for example, large hospitals – to use every artifice to maximize their profits. This reality presents both challenges and opportunities for the MLC and the City to work together to generate savings by leveraging their large size buying power, addressing loopholes and educating/incentivizing members to seek quality care from providers that eschew these bad tactics.

Understanding these challenges, the MLC and the City endeavored through the last two healthcare agreements to tackle these problems head on. Working through the Tri-Partite Healthcare Committee (comprising representatives of the MLC, City and chaired by Arbitrator/Mediator Martin Scheinman) targets for savings were set and options were stated to accomplish them. Together, we hit those targets, generating some $4.5 billion in recurring savings *without sacrificing benefits or significant additional cost*. Most of the changes were to plans covering in-service members and pre-Medicare retirees and their eligible dependents, although some changes had been made to plans for Medicare-eligible retirees and dependents.

While these efforts were significant and successful, the cost of healthcare continues to rise steeply all over the country. Further complicating our specific situation is that the cost for the GHI-CBP program is outpacing that of the HIP-HMO program which results in a significant drawdown of the jointly overseen Stabilization Fund. The Stabilization Fund successfully served its purpose for some 40 years, but now has run its course unless dramatic changes are made. The Fund provides a variety of benefits for in-service and retirees including covering chemotherapy and injectables, benefits for orphans and widows and additional support for in-service and retiree welfare funds that typically provide prescription drug and other supplemental benefits.

The Tri-Partite Committee's charge thus has been to find short- and long-term solutions to the rising cost of healthcare all the while ensuring quality healthcare and the preservation of benefits.

This effort was reported and discussed at MLC Steering Committee and General Membership meetings throughout the process, with votes being had where appropriate. One matter the Tri-Partite Committee was specifically charged with considering was a Medicare Advantage ("MA") construct for that incorporated federal subsidies into the program which would advance the goal of healthcare cost savings. This provided additional funding for the Stabilization Fund without reducing benefits. To be clear, the MA program was not the sole focus of the Committee. The Committee has explored options (including those suggested by member unions) related to both in-service/pre-Medicare plans and Medicare-eligible plans. Many of those are in the process of being developed and implemented.

Understanding the shortcomings of many MA programs, the MLC members of the Committee were vigilant to reject any construct that would be narrow, reduce benefits or add out-of-pocket costs. At the MLC's insistence, the requests for proposals specifically required bidders to mirror the benefits offered by existing programs with a broad network, while permitting pre-authorizations that practically mirrored what employees and pre-Medicare retirees have.

After months of hard work, the parties were able to come to a historic agreement to leverage the availability of federal subsidies to arrive at a MA program that mirrored existing benefits and continued to provide a premium-free option for retirees. In fact, we succeeded in negotiating *additional* benefits beyond what the current benchmark plan offered. Recognizing that change may be difficult for some, the MLC pressed to (i) have the award given to an alliance of Empire BlueCross and Emblem Healthcare, our known providers, and (ii) maintain a choice of plans, allowing member to pay up and remain in the existing Medigap Plan. While some would have preferred that the Medigap Plan remain free, allowing it to continue without cost would have eroded the anticipated pricing savings. In short, that option is unworkable and would effectively cede the estimated $600 million in annual savings altogether. While other changes and programs being implemented will also generate savings (and are being pursued), they are in addition to and not instead of the anticipated savings from the MA program that was approved by the MLC.

Despite these realities, a small group of retirees commenced a misguided lawsuit that not only challenged the MLC/City's right to make changes to retiree healthcare but the MLC's right to negotiate for retirees at all. While the Court appropriately rejected those claims, it found that a provision of the Administrative Code precluded the City from charging up for an optional retiree healthcare plan should it cost less than what was expended for in-service workers, this (i) despite the fact that plan provided a full-service program and the existing retiree one was but a supplemental plan and (ii) retirees have for years had the option to pay up for other plans even though the benchmark plan cost less than the HIP-HMO. Contrary to some reports, the Court specifically allowed the MA plan to be implemented and indicated that the City satisfied its statutory requirement simply by offering an MA plan premium-free. The litigation consequently had the effect of (i) delaying implementation of the MA plan (thus reducing the opportunity for savings and accelerating the draw-down of the Stabilization Fund) and (ii) limiting the MLC's ability to insist on continuing to offer GHI Senior Care alongside MA as a pay up. The City's predictable response was to push for the MLC to abandon GHI Senior Care as an option. The MLC refused for we believe it essential that our community—in-service and retirees—be accorded options. The MLC and City are currently negotiating with the other bid finalist, Aetna, to step in for the initial successful bidder, which, with the delays attendant to the litigation,

declined to continue its commitment. In these renewed discussions, the MLC will not agree to move forward unless we are satisfied that Aetna will deliver a broad provider network and built-in protections to make sure we continue to have a robust premium-free health plan for retirees.

Even with these long-term efforts, the time for action can no longer be delayed. Thus, in light of escalating costs not the least of which are caused by the behemoth hospital systems, the MLC and the City are preparing an RFP to see if we can arrive at more efficient systems for in-service/pre-65 members that preserves or improves quality of care and continues to provide premium free plans while utilizing our purchasing power to generate savings and provide quality healthcare.

To obtain clarity and avoid further delay regarding the previously approved MA plan, the MLC has also agreed to support local legislation to amend the New York City Administrative Code to remedy the erroneous decision in the MA litigation. Two aspects remain unaltered: (i) retirees, actives and their dependents are entitled to a benchmark premium-free comprehensive plan and (ii) the HIP-HMO rate continues to be the default benchmark for in-service/pre-Medicare retirees. These matters cannot be changed without MLC consent and if the MLC refuses, that impasse cannot be addressed in arbitration and therefore it cannot be imposed upon the unions, providing greater protection than now available. And, while some contend that we are forfeiting plan protection, they miscomprehend the current system: the Administrative Code nowhere defines a minimum plan design for the HIP- HMO or any other plan. Plan design has always been subject to collective bargaining.

The bottom line is that our considered effort has allowed us to remain the only major municipal workforce that provides premium-free benefits for actives and retirees. Not only are those programs premium free, but they are superior to benefits offered to public employees in other major cities. The MLC has been a stalwart guard of these benefits for more than half a century and will long continue that battle.