



**SCHEINMAN**  
ARBITRATION & MEDIATION SERVICES

December 15, 2022

**Via E-Mail only**

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**Re: City of New York  
and  
Municipal Labor Committee  
(Medicare Advantage)**

Dear Counsel:

Enclosed please find my Opinion and Award in the above referenced matter. My bill for services rendered will be issued separately.

Thank you.

Sincerely,  
*Martin F. Scheinman*

MFS/sk  
City of NY.M.L.C.Medicare Advantage.trans

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In the Matter of the Dispute	X	
between	X	
CITY OF NEW YORK	X	
"City"	X	Re: Medicare Advantage
-and-	X	
MUNICIPAL LABOR COMMITTEE	X	
"MLC"	X	
-----	X	

**APPEARANCES**

**For the City**

Renee Campion, Commissioner of Labor Relations  
Daniel Pollak, First Deputy Commissioner  
of Labor Relations  
Nicole Andrade, Esq. General Counsel of Labor Relations

**For the MLC**

STROOCK & STROOCK & LAVAN, L.L.P.  
Alan M. Klinger, Esq.  
Dina Kolker, Esq.

**Before:** Martin F. Scheinman, Esq., Impartial Chairperson of  
the Tripartite Health Insurance Policy Committee and  
designated Arbitrator

## BACKGROUND

The Municipal Labor Committee ("MLC") was established in 1967 and codified in Sections 12-313 of the Administrative Code of the City of New York ("City"). It is an association of the City's public sector unions which represent approximately three hundred ninety thousand (390,000) active uniformed and civilian employees, and whose mission is to facilitate the collective bargaining process with the City by collectively addressing common concerns of its members, particularly with regard to the negotiation of and administration of citywide health benefits. It also represents approximately two hundred fifty thousand (250,000) retirees with regard to City health benefits.

By letter agreement dated June 28, 2018, the City and the MLC agreed to a series of measures to address the delivery of healthcare, focused on preserving the quality of healthcare for active employees, retirees and dependents while stemming the rising costs. ("2018 Agreement"). See Attachment A. While acknowledging the prior healthcare agreement between the parties had accomplished significant savings, it was nonetheless recognized the long term sustainability of the premium free health care program for workers and their families required further study and innovation. See 2018 Agreement, at Sec. 5. Of particular concern was the diminishing status of the Stabilization Fund, a fund jointly controlled by the City and MLC that provides

significant assistance to both the City and the MLC unions and their benefit plans covering both active and retired members. To assist in meeting these overall goals, the parties formed a Tripartite Health Insurance Policy Committee ("Tripartite Committee") consisting of City and MLC members. I was duly appointed as the Impartial Chairperson of the Tripartite Committee. I am also the designated arbitrator for disputes arising under the 2014 and 2018 health agreements.

The Tripartite Committee was charged with studying a variety of topics, including specifically, "the status of the Stabilization Fund" and "the adoption of a Medicare Advantage benchmark plan for retirees." Id. at Section 5(b). Because of the inevitable overlap between studying more efficient methods of delivering health benefits and accomplishing the healthcare savings set out in the 2018 Agreement, the Tripartite Committee has served both as savings committee and catalyst for change. Through the work of the Tripartite Committee, among other things, the City and MLC engaged in a historic procurement process to create a custom Medicare Advantage plan ("MA" plan) for City retirees that would be offered alongside the option to pay up to remain in the current most popular Medigap plan, Senior Care.

However, before the new MA plan could be implemented, a small group of retirees sued to halt the process and generally seek to stop any change to retiree health benefits. The suit and its

resulting decision caused considerable delay, leading to one of the selected vendors abandoning the project. As set out herein, under my guidance, the parties have worked diligently and in good faith to move past these hurdles, pressing their rights on appeal, reaching out to the City Council for an amendment to address the court decision and beginning negotiations with the next qualified bidder, Aetna.

Nonetheless, time does not wait and the mounting deficit in the operation of several components of the citywide health plan continue. Although the parties collaborated in good faith to implement plans to save the agreed-to \$1.1 billion, the City is no longer able to realize a portion of those savings through the Stabilization Fund. The \$600 million anticipated savings from MA would have helped bridge the gap, but has been severely delayed. The City maintains it is owed over a billion dollars and now invokes my jurisdiction under the 2018 Agreement asking I issue a ruling on how to stem the increasing deficit, including whether and how the MA plan should be implemented. The City also asks for such other and further relief as may be appropriate.

#### **DISCUSSION AND FINDINGS**

The basic issue presented for decision is as follows:

1. Is the Stabilization Fund able to meet its contractual obligations and, if not, what shall the

remedy be for amounts owed in satisfaction of the 2018 Agreement?

**I. Structure and History of Citywide Benefits**

The provision of citywide health benefits is governed by both state and local law. The general obligation of the City to pay the basic cost of health insurance for employees and retirees is provided for under Section 12-126(b)(1) of the City Administrative Code:

The city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis..

N.Y. Admin. Code §12-126(b)(1). This statutory obligation and its specific reliance on the cost of the HIP-HMO rate, on a category basis, is the hub of certain health benefit policies. Overlaid on this funding requirement is the City's general obligation to bargain in good faith regarding the provision and administration of health benefits under both the New York State Public Employees' Fair Employment Act (the Taylor Law) and its local analogue, the New York City Collective Bargaining Law. Accordingly, for some half century, citywide health benefits offered to City employees and retirees have been negotiated and jointly administered by the City and the MLC.

While the structure has evolved over time, it generally consisted of the following components:

1. **City-provided medical/hospital coverage for active employees, pre-65 retirees and eligible dependents.** While the City offers several plan options, the most popular are the HIP-HMO plan and the GHI/Empire-CBP PPO plan ("GHI-CBP"). These plans provide comprehensive coverage. While the Administrative Code requires the City fund the full cost of these benefits up to the cost of the HIP-HMO rate, it does not require any other more expensive plan be offered premium free. Nor does it require any specific plan design be offered.
2. **City-provided medical/hospital coverage for Medicare-eligible retirees and eligible dependents.** Most of the plans available for this category of insured are Medigap plan. Senior Care, which historically has been the most popular plan, is a Medigap plan. Medigap plans do not provide comprehensive coverage. Rather, as the name indicates, they fill a gap left by traditional Medicare. Retirees are required to enroll in Medicare, which covers approximately 80% of the benefit. While the City is obligated to reimburse certain (Part B) Medicare premiums, the benefits themselves are paid for by federal funding. Medigap plans like Senior Care provide coverage for most of the remaining 20% of benefits.

**3. Prescription Drug Benefits.** Prescriptions drug benefits are provided either through union-administered welfare funds or the purchase of available drug riders. Many City unions have either separate active and retiree welfare funds or combined welfare funds. Many of those funds provide prescription drug benefits as well as other supplemental benefits such as dental, vision and the like. Other funds might provide a reimbursement for the cost of the City-offered prescription drug rider. For those not covered by a union fund benefit, they may purchase an appropriate rider. Union welfare funds are primarily funded by the City (and related employers) through collectively bargained arrangements with individual unions. However, as explained below, some funding and support is also provided pursuant to citywide MLC agreements through the Stabilization Fund.

Underscoring the importance of the work of the Tripartite Committee, the above described construct provides essential benefits to some 1.2 million covered lives:



Pre-Medicare Plans	
Actives	331,819
Pre-Medicare Retirees	75,500
Splits <sup>1</sup>	13,742
Dependents	537,359
<b>Total Covered Lives</b>	<b>958,420</b>

Medicare Plans	
Medicare Retirees	177,879
Splits	13,742
Dependents	65,492
<b>Total Covered Lives</b>	<b>257,113</b>

<b>Grand Total Covered Lives:</b>	<b>1,215,533</b>
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To provide a choice of benefits and address the escalating cost of certain benefits in particular, as relevant here, the City and MLC have over time also created the following funding mechanisms:

A. The Stabilization Fund

While the City, through collective bargaining, had long offered a choice of plans to active employees, the costs and plan design of those benefits were subject to collective bargaining as the Administrative Code required only that the City fund a plan up to the HIP-HMO rate, not that it offer any particular plan or choice of plans. In 1982, to provide a second premium-free choice for actives, the MLC and City agreed to "equalize" the premium rates charged for the HIP-HMO and then GHI/Blue Cross plans. This arrangement became known as the "Equalization Agreement." Its impact continues and is the reason why even today the GHI-CBP plan has been offered premium-free even when, as now, it costs more than the statutory benchmark HIP-HMO rate.

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<sup>1</sup> Split contracts are instances where a member and dependent are enrolled in different retiree plans because one is Medicare-eligible and one is not.

A short time after equalization, to stave off benefit erosion and fund the Equalization Agreement, the parties created a health insurance stabilization reserve fund (the "Stabilization Fund"). Per the agreement, the City would make certain contractual annual contributions to the fund and the resulting reserve would be used to pay for equalization (i.e., the difference between the HIP rate and the GHI-CBP premium rate). By contrast, when the HIP rate exceeds the GHI-CBP rate, the City would pay the difference into the Stabilization Fund, which allowed Stabilization Fund to grow in size. With the availability of these funds, since June 1985, the parties have mutually agreed to use monies from the Stabilization Fund to provide additional benefits, pay for specialty prescription drugs, assist union welfare funds, avoid layoffs, support collective bargaining and pay for the administrative costs associated with benefit cost savings programs. The Stabilization Fund construct has succeeded in providing the GHI-CBP plan premium-free as well as various additional benefits for decades. However, the rising costs of the GHI-CBP plan above the HIP rate has severely depleted the Fund, putting these benefits in jeopardy. Until a different paradigm exists, the Stabilization Fund's solvency is critical for workers, retirees and the City.

Currently, the Stabilization Fund is the source for the following categories of payments:

- Equalization of the GHI-CBP premium.
- Minimum Premium plan annual settlements.
- PICA Drug Plan (explained in next section).
- Administrative costs associated with various supplemental health improvement and care management programs provided through vendors or insurance carriers (e.g., GHI Home Care; HIP Mental Health Subsidy; Emblem Diabetes Management Program; Weightwatchers Program; Empire WIN Fertility; Teladoc Telemedicine Program; and site of service redirection).

- Welfare fund contributions on behalf of widows/ers and orphans of those killed in the line of duty so that they can continue receiving supplemental benefits.

- Supplemental Contributions to union welfare funds, including those serving retirees.

- Payments to the City based on prior health benefits savings agreements.

- Various related administrative expenses (e.g., NYCHSRO audits and consultant fees).

- Annual Insurance Reserve for CBP Program (Empire and Emblem; held, not paid).

As of the writing of this Award, the Stabilization Fund is effectively out of money. While some hundreds of millions of dollars of cash remain in the account, those sums are committed to required reserves with any net positive balance existing as a

result of the delayed processing of obligations of several hundred millions of dollars owed.

**B. The PICA Program**

As explained above, a large portion of active and retired members receive prescription drug coverage through their union-administered welfare fund. Over the years, the cost of certain specialty drugs became an unsustainable burden for the various welfare funds. To ensure these life-savings drugs would continue to be available, in 2001, the City and the MLC agreed to shift the costs of certain expensive prescription drugs to the Stabilization Fund. These are known as PICA (psychotropics, injectables, chemotherapy, and asthma) medications. PICA now only covers injectable and chemotherapy drugs at a cost of over \$400 million a year. Psychotropics and asthma drugs have been shifted back to the welfare funds to reduce costs to the PICA program.

**II. The Skyrocketing Cost of City Benefits:**

National health expenditures grew to \$4.1 trillion in 2020 and are expected to continue to grow at an average annual rate of 5.4% through 2028, when it is expected to reach \$6.2 trillion.<sup>2</sup>

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<sup>2</sup> See National Health Expenditure Fact Sheet, Historical NHE, 2020, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>.

The effects of these increased costs have been experienced disproportionately in New York in particular, with per capita spending in New York some 37% higher than the national average. In fact, from 2014 through 2020, the average growth in per capita health spending was higher in New York than any other state at 6.1%.<sup>3</sup>

Many factors have contributed to these skyrocketing costs, including changes in government regulations, the direct-to-consumer advertising of prescription drugs, the advent of expensive blockbuster drugs, the consolidation of hospital networks and billing practices by large institutions. All this has had a direct effect on City spending and the ability to sustain current health benefit structures.

In 2011, the Affordable Care Act further changed the landscape, requiring all employers to offer health care coverage with an expanded list of requirements such as extending dependent child coverage to age 26, which was estimated to cost the City an additional \$65 million per year. These new requirements provided important protections for consumers and employees, but the additional cost was also borne by the city benefits program.

The City currently spends some \$9.4 billion on providing direct health coverage to actives and dependents. In addition,

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<sup>3</sup> Id.

the City makes contributions of approximately \$1.4 billion per year to the various union welfare funds, which typically provide prescription drug benefits for non-specialty drugs, dental and other programs. Prescription drugs represent most of the cost of the benefits provided by the funds.

By 2023, the cost of providing all the health benefits to employees and retirees is expected to exceed \$11 billion and will, thereafter, continue to escalate.

### **III. Efforts to Deliver Quality Benefits More Cost Efficiently**

Striking the right balance between rising healthcare costs and the provision of robust, quality benefits has been the focus of near constant work by the MLC and the City for decades. Indeed, as early as in 1976, one (1) of the first joint City-MLC committees was created to develop and maintain cost savings programs. With steeply increasing healthcare costs in the most recent ten (10) years, those efforts intensified. The shared goal has been to leverage market power, make healthcare more efficient and less costly while avoiding the trend of having participants and beneficiaries contribute to the cost of premium.

To that end, the City and MLC entered into a historic healthcare savings agreement in 2014 (the "2014 Agreement"). At the time, the City was in the *sui generis* position of having the

outgoing Mayor leave every City collectively bargaining agreement expired.

The parties realized then because the rate of medical/hospital care inflation was outstripping regular inflation, the provision of high quality healthcare was going to jeopardize the ability to stay true to the goal of keeping the core healthcare programs premium-free while retaining the wide range of options. To preserve the quality of benefits, the parties agreed to an ambitious plan to save \$3.4 billion over four years; \$400M in FY 2015, \$700M in FY 2016, \$1B in FY 2017 and \$1.3B in FY 2018, with the \$1.3B being of a recurring nature. The parties successfully accomplished those targets, while minimizing the impact on members. Changes implemented overwhelmingly focused on the active/pre-65 plans. While plan designs remained relatively consistent, Emergency Room co-pays and office visit co-pays were increased for members. In addition, a care management program for Empire's hospital services was introduced which required doctors to get permission to perform certain hospital services. Other changes did not impact the members, such as the Emblem component of CBP becoming a minimum premium plan, putting the PICA plan out to a competitive marketing. After the MLC/City pressured it to do so, Emblem renegotiated with its radiology network and adjusted its physician network removing inefficient providers, to name a few.

In the following round of negotiations, the parties agreed to generate additional recurring savings of \$200M in FY 2019, \$300M in FY 2020 and \$600M in FY 2021. This totaled \$1.1B over those three (3) years.

Over the span of some eight (8) years, the two (2) successful agreements entered into by the MLC and City generated a total of \$4.5 billion dollars in savings. These agreements instituted the most transformational changes to the City's health plans in decades and led to many new and innovative programs. Some of the most impactful changes utilized behavioral economic incentives to encourage more appropriate use of healthcare, resulting in significant decreases in emergency room care and increases in preventive and primary care. Other key initiatives included Center of Excellence programs, a Fertility Management program, dependent eligibility audits, Telemedicine, site of service care-redirection programs, eliminating inefficient providers within the physician network, new care management programs and bidding out the PICA specialty drug program.

Much of the work to accomplish savings under the 2018 Agreement was facilitated under my guidance as part and parcel of the work of the Tripartite Committee. For example, the parties strove to create a more transparent and efficient system for the provision of quality care. They lobbied for legislation in support of laws to create pricing transparency and avoid surprise billing.



The Hospital Equity and Affordability Legislation (HEAL Act), awaiting the Governor's signature, bars anti-disclosure clauses, which are contractual provisions that prevent a party to the contract from revealing actual claims costs, negotiated rates or discounts, or patient cost-sharing data (protected health information would remain privileged and could not be disclosed).

The parties engaged directly with the largest insurance companies in an effort to leverage market power, securing reduced rate increases. By agreeing to "mandatory enrollment" of new employees into the HIP-HMO plan, versus employees otherwise being offered a choice of eleven (11) plans, there was a reduction of the increases being faced which, otherwise, would have been greater.

The parties also attempted to engage with private hospital systems to find efficiencies and to prioritize systems that would provide better pricing. These efforts have proved less successful, and will be at the core of the Negotiated Acquisition process underway for the primary medical plan.

Finally, in the interest of obtaining high quality healthcare more efficiently, individual union welfare funds experimented with programs to utilize government subsidized pricing for certain drug treatments. These have been largely successful.

#### **IV. THE STABILIZATION FUND CONTINUED TO BE DEPLETED**

Despite these efforts, the drawdown of the Stabilization Fund assets was accelerated due the overall rising cost of healthcare, the delays and uncertainty attendant to the COVID pandemic, the GHI-CBP rate exceeding the HIP HMO rate by significant amounts in recent years and the cost of starting up many of the innovative programs.

Recognizing the Stabilization Fund's monies were being depleted at a quicker pace, the parties intensified their efforts to reimagine the entire structure of how healthcare is to be provided. This involved a massive undertaking regarding active employees to create the pending negotiated acquisition or procurement to look at integrating the delivery of health benefits for active/pre-65 members, with the goal of reducing the City's overall projected cost by 10%. This over \$1 billion moonshot is underway.

Recognizing these challenges, the parties continued to work (through the Pandemic) on innovative approaches to both short-term and long-term savings. As to retirees who heretofore had been only rarely affected by the changes that actives and pre-65 retirees had been subject to, described above, after years of discussions with expert consultants for the City and MLC (Milliman and Segal, respectively), the City and MLC agreed to issue a negotiated acquisition or procurement for a robust MA program

mirroring and improving upon existing benefits. Given the size of the City retiree population, the opportunity to avail the City and MLC of a robust MA program for retirees in terms of benefits, panels of doctors, access to the most well-known and highest rated health systems country-wide was available.

It was anticipated the MA plan would generate \$600 million a year in savings effective January 1, 2022. These savings were to be achieved not by cutting benefits or reimbursements, but by taking advantage of federal programs and funding that would obviate the need for the City to pay for the last 20% of the benefit. Significantly, the parties agreed all savings would support the Stabilization Fund to tide it over while the potential overhaul of the entire healthcare system could proceed deliberately through the pending negotiated acquisition or procurement for actives and other undertakings.

This MA Negotiated Acquisition went through assessment and analysis leading to two (2) finalists. Both were determined to be qualified. But, the MLC preferred the Alliance (a joint bid by existing City insurers Empire Blue Cross Blue Shield and EmblemHealth, companies familiar to retirees and the MLC, as these companies had long serviced actives and retirees). The City preferred Aetna, given Aetna's greater experience in providing MA throughout the country and in New York City. The matter was referred to me for a recommendation to break the impasse. In

balancing those factors, I recommended the Alliance be selected. See June 24, 2021, recommendation, annexed as Attachment B. The selection committee subsequently awarded the MA contract to the Alliance.

To nevertheless provide ample choice to retirees, despite the lost savings opportunities, the City and MLC agreed to retain the right of an individual retiree to remain in Senior Care, paying for this selection at approximately \$191 per month. Once enrolment began, unsurprisingly, a large percentage remained in the MA plan because it met their needs and whatever differences existed between MA and Senior Care did not warrant the cost differential. Experience with other customized MA programs demonstrated to me that they can offer quality benefits resulting in high levels of members satisfaction, even when those members are themselves retired health professionals, like in the Hospital/1199SEIU plan.

## **V. LITIGATION**

However, that implementation was delayed by a lawsuit filed by a small group of unaffiliated retirees. The delay has sacrificed at least \$900 million dollars that could have supported the Stabilization Fund. It also generated the need to act quickly to resolve the issue in order to maintain premium-free coverage under the GHI-CBP plan, which is paid for by the Stabilization Fund.

The retirees initially sued claiming the MA plan was inferior, that their retiree healthcare benefits were frozen and could never be changed, that the MLC had no authority to negotiate regarding retiree benefits and that a state law applicable to school districts precluded any change in retiree benefits. All those claims were ultimately rejected. But, the retirees were able to obtain a temporary restraining order delaying the start date for the MA plan on the basis that insufficient and/or inaccurate information was being provided to retirees during the opt-out period. The Court ordered the parties to improve the roll-out process so that retirees could make informed choices.

As that process moved forward, the retirees developed an additional argument, claiming that the Administrative Code required the City to pay up to the active benchmark (the HIP-HMO rate) for retiree plans, thus preventing the City from being able to provide Senior Care as a pay-up option alongside MA.

Although ultimately approving of the MA roll-out, Judge Lyle Frank agreed with the retirees so long as Senior Care cost less than the HIP-HMO rate, the City could not "charge up" for it. This reasoning is curious in that the actives plan is a comprehensive one whereas the retiree program is a supplemental one. Yet, Judge Frank understood the City's concern about its ability to provide a benchmark plan on financial terms that are advantageous if it is required to provide all other optional plans for free as well; in

so doing, the Judge Frank pointed out while the Administrative Code requires the City pay for Senior Care if offered, it does not require the City to offer it. That decision has now been affirmed on appeal, with appellate Judges pointing out the same potential consequence of their decision.

Unsurprisingly, this ruling caused great uncertainty for retirees. Some that had selected MA changed their choice and reenrolled in Senior Care. After all, some assumed Senior Care must be a better program since it was going to cost more to enroll in it in contrast to MA. No one adequately explained the price differential was largely the result of the Federal subsidies unavailable for Senior Care. Others simply chose Senior Care because this is what they were familiar with and, understandably, change is frightening. Another contributing factor was that the Alliance was simply unprepared to respond to the rumors and inaccurate statements about the Alliance MA offering, e.g., doctors would not accept MA and certain Hospitals would reject patients covered by MA. These claims were almost universally untrue.

While this was going on, the Alliance was in contact with the City and the MLC indicating the uncertainty as to whether Senior Care would be available at no cost was making it impossible to proceed with enrollment as cost estimates were premised on the fact most retirees would over time migrate to MA because the

program was enticing and the cost of Senior Care would not justify an informed retiree to pay an additional premium for Senior Care. Empire, the co-sponsor of the Alliance plan, ultimately determined if a final decision on the scope of the program was not made by July 15, 2022, it would withdraw from the Alliance and would no longer be willing to offer the MA program to NYC retirees.

At this point, although the MLC had consistently attempted to preserve the Senior Care option, pressure was mounting to move ahead without Senior Care. One (1) remaining avenue to restore the MLC's ability to negotiate for pay-up options for retirees was to persuade the City Council to amend the Administrative Code so as to restore the lost bargaining flexibility, namely, free MA or Senior Care at a premium up charge. The City and the MLC jointly agreed to propose legislation, and sought to persuade the Council to act. As time passed without action, a number of MLC unions pressed the Tripartite Committee to wait longer for the City Council to act as it strongly preferred giving retirees a choice. The MLC and the City also hoped the Appellate Division might overturn Judge Frank's determination. It did not.<sup>4</sup>

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<sup>4</sup> Unfortunately, the retiree group's pressing to avoid paying \$191/month for Senior Care has led, potentially, to a worse situation: the removal of all the previously provided pay up options which the Tripartite Committee had worked to preserve so retirees had a choice.

During early Fall 2022, reports back from certain Union Leaders were that the City Council was strongly considering the proposed amendment to provide retiree choice. The Tripartite Committee was optimistic this could happen as the MLC and the City were in agreement this was the preferred choice to effectuate their mutual decision. The parties requested I write the City Council to set forth the dire circumstances at hand. I did so. See letter dated September 30, 2022, annexed as Attachment C.

Yet, at this time, no legislation has been introduced and the prospects of passage of a change to the Administrative Code remains uncertain. The loss of \$50 million a month in savings by the delay in beginning MA increasingly makes it likely much of the healthcare provided through funding from the Stabilization Fund will expire resulting in loss of essential treatments and benefits for actives and retirees. Such an outcome is untenable. Therefore, as required pursuant to the authority vested in me by the 2018 Agreement, incorporating by reference the 2014 Agreement, I have determined it is time to address the MA matter definitively.

#### **VI. Aetna**

As the Alliance is no longer an available alternative, Aetna, the other finalist, may be considered pursuant to City procurement law. As noted above, Aetna was found to be fully qualified. As a result, consistent with City's procurement rules and the process



established by the City and the MLC, various meetings were held with Aetna to confirm the program promised would, in fact, be delivered. The Tripartite Committee also addressed matters that had gone awry with the Alliance implementation efforts. I attended a meeting with the Aetna leadership to weigh its answers, responsiveness to the City and the MLC and to evaluate whether it would be the partner the parties deserve.

As Chair of the Tripartite Committee, I am comfortable Aetna now is the right partner and that starting a new procurement process for MA is not practicable. I am aware one of the Aetna MA plans incurred a decrease in its "star rating". However, Aetna has represented the City retirees will be moved to a plan which maintains a 4.5 MA star program subject to CMS regulatory approval. Moreover, the MLC officers and I pressed the Aetna representatives on the steps that would be taken to ensure that City retirees would receive quality care. I was persuaded that the Aetna program would meet the needs of the City retiree population. I find support in this view by the experience of some 45,000 Hospitals/1199SEIU retirees - a relationship with which I have significant familiarity - who moved to Aetna and have extended their participation beyond the initial contract period. This positive view is buttressed by the experience of the State of New Jersey's 200,000 retirees who after a series of contracts with Aetna recently extended its relationship with them for years five (5) and six (6). Similarly,

the State of Ohio's Teachers and School Employees have been with Aetna's MA program for more than ten (10) years and the Commonwealth of Pennsylvania's 80,000 retirees have been with Aetna MA for ten (10) years. Given these successes, it is appropriate and essential for the parties to utilize the significant federal subsidies available to help bridge the savings gap.

I understand some have claimed the requisite savings are being made "on the back" of the retirees. Nothing could be further from the truth. In the more than eight (8) years I have been intimately involved in these healthcare matters, the lion's share of changes have been to the actives and pre-Medicare retirees groups. As described above, numerous care management programs (including Prior Authorizations for active and pre-Medicare retirees for certain procedures, and case management for those deemed as large claimants), site of service diversions and similar programs have been implemented in connection with the GHI-CBP plan. Co-pays were added and increased to drive more efficient utilization of services.

For example, upon realizing covered individuals were using emergency room visits where less expensive primary care or urgent care visits would be more appropriate, the parties agreed to increase the emergency room co-pay to \$150 to drive more efficient

use.<sup>5</sup> Further, the Emergency Room was being used as a source of Doctor Notes employees need in order to receive pay when ill. The City's Doctor Note policy has been changed to allow telemedicine to create doctors notes for the City, which further decreased Emergency Room use. Office Visit co-pays were also adjusted so that true Primary Care Physicians would cost \$15 while Specialists would cost \$30, unless the Physician were part of ACPNY, in which case the co-pay became \$0 (to use the Emblem clinic model, which is a financially more advantageous form of care for the City to incentivize). Additionally, in 2020, the PICA plan adopted a modified drug formulary. Another program policy change was implemented which restricted new hires to enroll only in the HIP HMO plan, ensuring there would be fewer claims out of network. As recently as October 2022, the City and the MLC agreed to increased co-pay for non-preferred providers and renewed mandatory HIP enrollment for new hires to close a portion of the short-term deficit in the Stabilization Fund.

Yet, while these changes occurred impacting active employees, the increased costs of the Senior Care program were primarily managed through renegotiations with carriers that did not impact member experiences. It was only recently that the parties agreed to a modest change in co-pays under the Senior Care program and

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<sup>5</sup> If there was an admission after visiting the ER (indicating appropriate use of such care), no co-pay is due.

even that was delayed so as to avoid making changes during the height of the COVID pandemic.

While I understand change can be difficult, particularly when it comes to long-time health benefits, circumstances have evolved to threaten the sustainability of robust premium-free benefits for actives and retirees. Accordingly, it is appropriate actives and retirees share in thoughtful program changes as part of a larger restructuring of City health benefits. Many changes have already been made on the GHI-CBP front and the parties are actively engaged in a negotiated acquisition process regarding that plan. That process has long been completed for the MA plan and unless everyone is prepared to have actives and pre-65 retirees make significant premium contributions during the months that a new procurement process would span, it has come time to implement MA. Throughout my forty (40) some years as neutral - being primarily responsible for healthcare programs covering millions of employees and retirees - I have concluded premium shifting should be an act of last resort. It is a devastating outcome, especially for lower paid employees. For example, 20% of premium sharing would cost many employees and retirees covered as individuals at least \$6,000 per year. This is impossible for the vast majority of City active employees and retirees. Premium shifting also amounts to a bit of a shell game: employees believe they are receiving pay increases only to have those increases decreased or eliminated by having to

pay part of their healthcare premium they, heretofore, had not contributed towards.

### Opinion

The Tripartite Committee has worked tirelessly to find the right path forward. These efforts are a testament to the parties' commitment to finding a solution which addresses the needs of current retirees and future retirees while providing a sustainable income source to assure retirees and actives continue to receive high quality, state-of-the-art health coverage. One only needs to look at the experience of other municipalities and the threat to their retirees' health programs to recognize how these parties have done it better. Nonetheless, circumstances have brought us to difficult choices.

Preliminarily, I note it has taken years for the parties to have become comfortable with and agree to a negotiated acquisition bidding process for a MA product. For the years I have served as Impartial Chairperson of the Tripartite Committee, I have observed the good faith deliberations on how to proceed. Rest assured, getting to the point of selection from amongst two (2) qualified bidders has been a long, intensely vetted process. Hundreds of hours have been dedicated by professionals, the MLC and the City leadership to arrive at this final selection point.

I also recognize from published reports, and unsolicited communications with my office, this change is the source of considerable anxiety. MLC leadership has reported this fact to me frequently.

Similarly, the City has explained and demonstrated the fact retirees are receiving and the City is paying - directly or through welfare funds - for benefits and products which are not optimal. Simply stated, moving to a MA program for City retirees is prudent, responsible and essential.

Taking the totality of the circumstances into account, I have determined an MA plan should go forward to help alleviate the savings realization shortfall, that the MA plan be that of Aetna, and that I remand this matter to the City and the MLC for twenty five (25) calendar days to reach agreement with Aetna and, in particular, incorporate into the contract with Aetna the guarantees and penalties previously discussed with Aetna should the promises made by Aetna not be delivered on. These assurances must be verifiable and enforceable. These shall include a robust procedure for addressing denials of claims submitted by retirees so as to earn the trust Aetna has assured the parties it is committed to build.

Promptly, upon the conclusion of the negotiations period with Aetna, and subject to appropriate contractual protections having been negotiated with Aetna, the agreement shall immediately be put

to a vote of the MLC. Failure to have this agreement ratified shall result in finding another revenue source which, inevitably, shall lead to premium contributions. I will make myself available in the event of an impasse in these discussions with Aetna.

Further, there is still the possibility choice may be retained as the parties intended. However, unless the City Council amends the Administrative Code within forty five (45) calendar days of this Award to permit retirees to buy into Senior Care, as has been the preference and agreement of the Collective Bargaining parties, in order to comply with the decision of Judge Frank, as affirmed by the Appellate Division, Senior Care shall no longer be an offering. The Aetna MA plan will be available to retirees. The City and the MLC may also agree to offer other plans so long as they are at no cost to the City.

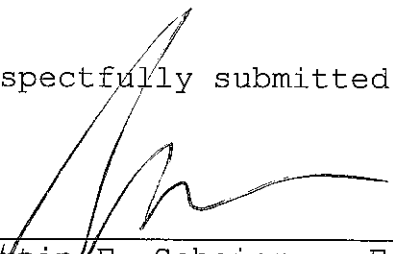
In order to ensure the ability to meet an implementation date of July 1, 2023, any delays to the time frames set forth in this Award, or disputes between the parties, shall be referred to me for expedited resolution within forty eight (48) hours of the referral.

The process underway shall continue as an essential element of the parties' mutual commitment to provide high quality healthcare coverage to active employees and retirees. The Tripartite Committee will continue to work with that procurement process for actives and pre-Medicare retirees to assure

efficiencies and the enormous buying power of the over one million covered lives for healthcare shall bring down the current anticipated spend on healthcare by over \$1 billion without sacrificing the quality and level of care the City workforce and their families deserve.

December 15, 2022

Respectfully submitted,



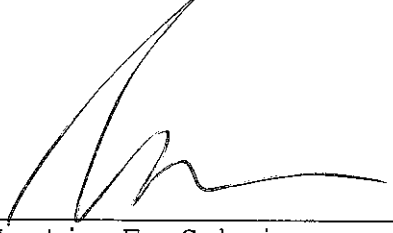
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Martin F. Scheinman, Esq.  
Impartial Chairperson of the  
Tripartite Health Insurance Policy  
Committee and designated Arbitrator

STATE OF NEW YORK    )  
                                  )    SS :  
COUNTY OF NASSAU    )

I, MARTIN F. SCHEINMAN, ESQ., do hereby affirm upon my oath as Impartial Chairperson of the Tripartite Committee that I am the individual described herein and who executed this instrument, which is my Recommendation.

December 15, 2022



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Martin F. Scheinman, Esq.  
Impartial Chairperson of the  
Tripartite Health Insurance Policy  
Committee and designated arbitrator



# **ATTACHMENT A**



# OFFICE OF LABOR RELATIONS

40 Rector Street, New York, N.Y. 10006-1705  
nyc.gov/olr

ROBERT W. LINN  
*Commissioner*

RENEE CAMPION  
*First Deputy Commissioner*

CLAIRE LEVITT  
*Deputy Commissioner*  
*Health Care Cost Management*

MAYRA E. BELL  
*General Counsel*

GEORGETTE GESTELY  
*Director, Employee Benefits Program*

June 28, 2018

Harry Nespoli, Chair  
Municipal Labor Committee  
125 Barclay Street  
New York, New York

Dear Mr. Nespoli:

1. This is to confirm the parties' mutual understanding concerning the health care agreement for Fiscal Years 2019 – 2021:
  - a. The MLC agrees to generate cumulative healthcare savings of \$1.1 billion over the course of New York City Fiscal Years 2019 through 2021. Said savings shall be generated as follows:
    - i. \$200 million in Fiscal Year 2019;
    - ii. \$300 million in Fiscal Year 2020;
    - iii. \$600 million in Fiscal Year 2021, and
    - iv. For every fiscal year thereafter, the \$600 million per year savings on a citywide basis in healthcare costs shall continue on a recurring basis.
  - b. Savings will be measured against the projected FY 2019-FY 2022 City Financial Plan (adopted on June 15, 2018) which incorporates projected City health care cost increases of 7% in Fiscal Year ("FY") 2019, 6.5% in FY 2020 and 6% in FY 2021. Non-recurring savings may be transferrable within the years FY 2019 through FY 2021 pursuant only to 1(a)(i), 1(a)(ii), 1(a)(iii) above. For example:
    - i. \$205 million in FY 2019 and \$295 million in FY 2020 will qualify for those years' savings targets under 1(a)(i) and 1(a)(ii).
    - ii. \$210 million in FY 2019, \$310 million in FY 2020, and \$580 million in FY 2021 will qualify for those years' savings targets under 1(a)(i), 1(a)(ii), 1(a)(iii).
    - iii. In any event, the \$600 million pursuant to 1(a)(iv) must be recurring and agreed to by the parties within FY 2021, and may not be borrowed from other years.

- c. Savings attributable to CBP programs will continue to be transferred to the City by offsetting the savings amounts documented by Empire Blue Cross and GHI against the equalization payments from the City to the Stabilization Fund for FY 19, FY 20 and FY 21, unless otherwise agreed to by the City and the MLC. In order for this offset to expire, any savings achieved in this manner must be replaced in order to meet the recurring obligation under 1(a)(iv) above.
    - d. The parties agree that any savings within the period of FY 2015 - 2018 over \$3.4 billion arising from the 2014 City/MLC Health Agreement will be counted towards the FY 2019 goal. This is currently estimated at approximately \$131 million but will not be finalized until the full year of FY 2018 data is transmitted and analyzed by the City's and the MLC's actuaries.
    - e. The parties agree that recurring savings over \$1.3 billion for FY 2018 arising under the 2014 City/MLC Health Agreement will be counted toward the goal for Fiscal Years 2019, 2020, 2021 and for purposes of the recurring obligation under 1(a)(iv) above. This is currently estimated at approximately \$40 million but will not be finalized until the full year of FY 2018 data is transmitted and analyzed by the City's and the MLC's actuaries. Once the amount is finalized, that amount shall be applied to Fiscal Years 2019, 2020, 2021 and to the obligation under 1(a)(iv).
2. After the conclusion of Fiscal Year 2021, the parties shall calculate the savings realized during the 3 year period. In the event that the MLC has generated more than \$600 million in recurring healthcare savings, as agreed upon by the City's and the MLC's actuaries, such additional savings shall be utilized as follows:
  - a. The first \$68 million will be used by the City to make a \$100 per member per year increase to welfare funds (actives and retirees) effective July 1, 2021. If a savings amount over \$600 million but less than \$668 million is achieved, the \$100 per member per year (actives and retirees) increase will be prorated.
  - b. Any savings thereafter shall be split equally between the City and the MLC and applied in a manner agreed to by the parties.
3. Beginning January 1, 2019, and continuing unless and until the parties agree otherwise, the parties shall authorize the quarterly provision of the following data to the City's and MLC's actuaries on an ongoing quarterly basis: (1) detailed claim-level health data from Emblem Health and Empire Blue Cross including detailed claim-level data for City employees covered under the GHI-CBP programs (including Senior Care and Behavioral Health information); and (2) utilization data under the HIP-HMO plan. Such data shall be provided within 60 days of the end of each quarterly period. The HIP-HMO utilization data will also be provided to the City's and MLC's actuaries within 60 days of the execution of this letter agreement for City Fiscal Year 2018 as baseline information to assess ongoing savings. The HIP-HMO data shall include: (i) utilization by procedure for site of service benefit changes; (ii) utilization by disease state, by procedure (for purposes of assessing Centers of Excellence); and (iii) member engagement data for the Wellness program, including stratifying members by three tranches (level I, II and III). The data shall include baseline data as well as data regarding the assumptions utilized in determining expected savings for comparison. The data described in this paragraph shall be provided pursuant to a data sharing agreement entered into by the City and MLC, akin to prior data agreements, which shall provide for the protection of member privacy and related concerns, shall cover all periods addressed by this Agreement (i.e., through June 30, 2021 and thereafter), and shall be executed within thirty days of the execution of this letter agreement.

4. The parties agree that the Welfare Funds will receive two \$100 per member one-time lump-sum payments (actives and retirees) funded by the Joint Stabilization Fund payable effective July 1, 2018 and July 1, 2019.
5. The parties recognize that despite extraordinary savings to health costs accomplished in the last round of negotiations through their efforts and the innovation of the MLC, and the further savings which shall be implemented as a result of this agreement, that the longer term sustainability of health care for workers and their families, requires further study, savings and efficiencies in the method of health care delivery. To that end, the parties will within 90 days establish a Tripartite Health Insurance Policy Committee of MLC and City members, chaired by one member each appointed by the MLC and the City, and Martin F. Scheinman, Esq. The Committee shall study the issues using appropriate data and recommend for implementation as soon as practicable during the term of this Agreement but no later than June 30, 2020, modifications to the way in which health care is currently provided or funded. Among the topics the Committee shall discuss:
  - a. Self-insurance and/or minimum premium arrangements for the HIP HMO plan.
  - b. Medicare Advantage- adoption of a Medicare Advantage benchmark plan for retirees
  - c. Consolidated Drug Purchasing- welfare funds, PICA and health plan prescription costs pooling their buying power and resources to purchase prescription drugs.
  - d. Comparability- investigation of other unionized settings regarding their methodology for delivering health benefits including the prospect of coordination/cooperation to increase purchasing power and to decrease administrative expenses.
  - e. Audits and Coordination of Benefits- audit insurers for claims and financial accuracy, coordination of benefits, pre-65 disabled Medicare utilization, End Stage Renal Disease, PICA, and Payroll Audit of Part Time Employees.
  - f. Other areas- Centers of Excellence for specific conditions; Hospital and provider tiering; Precertification Fees; Amendment of Medicare Part B reimbursement; Reduction of cost for Pre-Medicare retirees who have access to other coverage; Changes to the Senior Care rate; Changes to the equalization formula.
  - g. Potential RFPs for all medical and hospital benefits.
  - h. Status of the Stabilization Fund.

The Committee will make recommendations to be considered by the MLC and the City.

6. The joint committee shall be known as the Tripartite Health Insurance Policy Committee (THIPC) and shall be independent of the existing "Technical Committee." The "Technical Committee" will continue its work and will work in conjunction with the THIPC as designated above to address areas of health benefit changes. The Technical Committee will continue to be supported by separate actuaries for the City and the MLC. The City and the MLC will each be responsible for the costs of its actuary.
7. In the event of any dispute under sections 1-4 of this Agreement, the parties shall meet and confer in an attempt to resolve the dispute. If the parties cannot resolve the dispute, such dispute shall be referred to Martin Scheinman for resolution consistent with the dispute resolution terms of the 2014 City/MLC Health Agreement:
  - a. Such dispute shall be resolved within 90 days.

- b. The arbitrator shall have the authority to impose interim relief that is consistent with the parties' intent.
- c. The arbitrator shall have the authority to meet with the parties as such times as is appropriate to enforce the terms of this agreement.
- d. The parties shall share the costs for the arbitrator (including Committee meetings).

If the above conforms to your understanding, please countersign below.

Sincerely,  
  
Robert W. Linn

Agreed and Accepted on behalf of the Municipal Labor Committee

BY:   
Harry Nespoli, Chair

# **ATTACHMENT B**



**SCHEINMAN**  
ARBITRATION & MEDIATION SERVICES

June 24, 2021

**Via E-Mail Only**

Renee Campion, Commissioner of Labor Relations  
Steven H. Banks, Esq.  
New York City of Office Labor Relations  
The Office of Labor Relations  
22 Cortlandt Street, 14<sup>th</sup> Floor  
New York, NY 10007

Alan M. Klinger, Esq.  
Dina Kolker, Esq.  
Stroock & Stroock & Lavan, L.L.P.  
180 Maiden Lane, 33<sup>rd</sup> Floor  
New York, NY 10038

**Re: City of New York  
and  
Municipal Labor Committee  
(Medicare Advantage Provider Selection Recommendation)**

Dear Counsel:

Enclosed please find my Recommendation in the above referenced matter. I have also enclosed my bill for services rendered.

Thank you.

Sincerely,

Martin F. Scheinman, Esq.  
Impartial Chairperson of the Tripartite  
Health Insurance Policy Committee

MFS/sk

City of NY.MLC.medicare selection.trans

-----	X	
In the Matter of the Dispute		
	X	
between		
	X	
CITY OF NEW YORK		
	X	Re: Medicare
"City"		Advantage Provider
	X	Selection
-and-		(Recommendation)
	X	
MUNICIPAL LABOR COMMITTEE		
	X	
"MLC"		
-----	X	

**APPEARANCES**

**For the City**

Renee Campion, Commissioner of Labor Relations  
Steven H. Banks, Esq., First Deputy Commissioner  
and General Counsel of Labor Relations

**For the Union**

STROOCK & STROOCK & LAVAN, L.L.P.  
Alan M. Klinger, Esq.  
Dina Kolker, Esq.

**Before:** Martin F. Scheinman, Esq., Impartial Chairperson of  
the Tripartite Health Insurance Policy Committee



## BACKGROUND

The Municipal Labor Committee ("MLC") was established in or about 1967 and codified in Sections 12-313 of the Administrative Code of the City of New York ("City"). It is an association of the City's public sector unions which represent approximately three hundred ninety thousand (390,000) active uniformed and civilian employees, and whose mission is to facilitate the collective bargaining process with the City by collectively addressing common concerns of its members. It also represents approximately two hundred fifty thousand (250,000) retirees.

By letter agreement dated June 28, 2018, the City and the MLC agreed to a series of measures to address the delivery of healthcare, focused on preserving the quality of healthcare for active employees, retirees and their dependents while stemming the rising cost of its delivery ("Agreement"). See Attachment A. While acknowledging the prior healthcare agreement between the parties had accomplished significant savings, it was nonetheless recognized "the longer term sustainability of healthcare for workers and their families requires further study, savings and efficiencies in the method of healthcare delivery" (Agreement, at Section 5). Of particular concern was the diminishing status of the Stabilization Fund, a fund jointly controlled by the City and MLC provides significant assistance to both the City and the MLC unions and their benefit plans covering both active and retired

members. To assist in meeting these overall goals, the parties formed a Tripartite Health Insurance Policy Committee ("Tripartite Committee") consisting of City and MLC members. The Tripartite Committee is comprised of one (1) member each of the City and MLC. I was duly appointed as the Impartial Chairperson of the Tripartite Committee.

The Tripartite Committee was charged with studying a variety of topics, including specifically, "the status of the Stabilization Fund" and "the adoption of a Medicare Advantage benchmark plan for retirees." Id. at Section 5(b). To that end, the parties formed a Medicare Advantage Evaluation subcommittee ("Evaluation Committee"), comprised of equal representation of the City and MLC members, to oversee a negotiated acquisition bidding process for the award of a Medicare Advantage contract.

Four (4) major companies submitted bids and presented to the Evaluation Committee. After a series of discussions, the list was narrowed to two (2) finalists, Aetna and a joint venture type alliance of Anthem/Empire BlueCross/ Emblem Health (the "Alliance"). Aetna has a prominent and highly respected presence in Medicare Advantage. The Alliance includes entities that have long-provided quality medical and hospitalization coverage for the vast majority of the City's municipal workforce and retirees. In addition to being able to deliver healthcare services more affordably because of federal government subsidies available to

Medicare Advantage programs, both bids offered benefits beyond what is currently existing for retirees in the Senior Care program while allowing them access to the same doctors and the same hospitals as currently utilized.

After a series of best-and-final offers, the differences between the bids narrowed with Aetna providing better treatment in certain areas and the Alliance in others. After continued discussions it became clear the parties' respective healthcare consultants, principals and subcommittee members had not reached consensus with regard to the final bids. It is undisputed either bid would provide the City with some three billion (\$3,000,000,000) dollars in savings over the initial five (5) year contract period. The parties agreed all savings resulting from the implementation of the Medicare Advantage program would be directed to the Stabilization Fund to ease the situation there.

The Stabilization Fund was established in June 1985 by the City of New York and the MLC. The express purpose of the Stabilization Fund is to receive dividends, if any, from the GHI-CBP Plan, to provide a sufficient reserve for health benefits; to maintain to the extent possible the level of health insurance benefits provided under the Blue Cross/GHI-CBP plan; and, if sufficient funds are available, to fund new benefits. In addition, the Stabilization Fund is to pay any money due to the carriers as

a result of the Comprehensive Benefit Plan cost exceeding the HIP-HMO Rate (the equalization formula).

Since June 1985, the parties have mutually agreed to use the Stabilization Fund to pay for City budget needs, welfare fund contributions, prescription drug costs and administrative costs associated with benefit cost savings programs. Simply put, until a different paradigm exists, the Stabilization Fund's solvency is critical for workers, retirees and the City.

Projections going forward indicate a cash deficit in the Stabilization Fund will occur sometime in FY 2022. This of course is not a desired result and the parties are endeavoring to find a long term solution, one that should be collectively bargained. To facilitate this process, the parties have agreed all savings resulting from the Medicare Advantage program, anticipated to be more than five hundred million (\$500,000,000) dollars annually, will flow to the Stabilization Fund to support its operation. This is intended to allow sufficient time to arrive at a construct that maintains quality healthcare for the City's active and retiree members and does so at a cost affordable to the City.

Facing a complex series of savings and benefits in which the lack of a final decision threatens to deprive the City of much needed savings, the parties reached out to me as the Impartial Chairperson of the Tripartite Committee for an analysis of the proposals and a written recommendation regarding the evaluation

criteria set forth in the Negotiated Acquisition. While disputes pertaining to certain aspects of the Agreement were specifically delegated to me for resolution, a dispute as to the vendor was not. However, given the selection of a Medicare Advantage provider was an enumerated topic for the Tripartite Committee, the parties believed it appropriate to refer the matter to me. I have accepted that role. It is my understanding, as reflected in the May 28, 2021, letter from Labor Commissioner Renee Campion, to MLC Chair Harry Nespoli, (Attachment B), the parties have agreed to have their respective appointees to the Medicare Advantage Evaluation subcommittee take into account this Report and Recommendations in submitting their final scoresheets. To complete the procedural posture, once a vendor is selected, the implementation of this Medicare Advantage contract is contingent on a ratification vote of the MLC's membership. See Attachment B.

#### **DISCUSSION AND FINDINGS**

The basic issue presented for recommendation is as follows:

1. Which of the two (2) final bids for the provision of a Medicare Advantage plan received from Aetna and the Alliance do I recommend?

#### **Positions of the Parties**

The MLC insists the Alliance is the best choice to provide the Medicare Advantage to the New York City retirees. The MLC

maintains adopting a Medicare Advantage program will result in a program with enhanced quality of care opportunities for its retirees, and significant cost savings in maintaining and improving the healthcare benefits being provided to the MLC's retirees. According to the MLC, a key factor in the success of the program is a provider experienced in dealing with the retirees, their welfare funds and unions.

The MLC asserts change is always difficult to implement, but more so when the system is as complex as New York's City's retiree benefits program. The MLC contends the program involves almost two hundred fifty thousand (250,000) contracts, the New York City five (5) pension systems, the City's payroll system, the more than one hundred (100) welfare funds and unions, the Federal Medicare program, the Department of Education, the New York City Housing Authority and the Health and Hospital Corporation.

The MLC points out contract members are demanding and vociferous. According to the MLC, the contract members seek answers, cooperation, and understanding. It claims the contract members have to trust their problems will be solved by the provider.

The MLC insists only the Alliance provides a high degree of certainty in accomplishing this result. The MLC alleges only one (1) vendor possesses the market reputation and understanding of

its members' needs in order to ensure success. That vendor is the Alliance.

The MLC points out the Alliance has served the New York City retiree population for a long time. It maintains there has been a great deal of trust built between these carriers and the members. According to the MLC, the fear of change and movement into "the unknown" (new product) would be much easier dealt with in the hands of vendors they trust. It contends less fear will also allow for a smoother transition into this new product and far less panic by those retirees.

The MLC insists of significant importance would be the change in Medicare D Optional Drug Riders. According to the MLC, there is currently an unmeasured amount of disruption that would take place should Aetna take over this coverage. It contends the Alliance currently covers far more non-Medicare Part D drugs than Aetna, and unmeasured disruption for the Medicare D drugs due to using a different formulary is troublesome. The MLC submits if the Alliance is not the chosen provider members may be forced to move into the Medicare D Optional Drug Rider given they would have to leave any individual Medicare D plans which many retirees may currently be enrolled.

The MLC relies on the fact the Alliance is confident in its ability to operate this plan as a four (4) star rated plan. It avers the Alliance has supported this confidence by putting more

fees at risk than Aetna on an ongoing basis. According to the MLC, the Alliance, in an effort to ensure minimal up front implementation costs for the City, has agreed to implementation credits of up to seven million (\$7,000,000) dollars, wherein Aetna has only allowed for up to six million (\$6,000,000) dollars.

The MLC maintains while the Alliance offer falls short of Aetna's savings potential in year one, the shortfall of twenty two million (\$22,000,000) dollars represents less than five (5%) percent of the total savings opportunity for 2022, and less than one (1%) percent when amortized over the duration of the contract. In addition, the MLC submits the Alliance offers a more favorable gain share arrangement to the City, whereby they will begin paying if the Medical Loss Ratio falls below ninety five (95%) percent, versus ninety two and two tenths (92.2%) percent for Aetna. It insists with favorable claims experience the City could receive over \$80 million per year from the Alliance before Aetna begins paying any gain share.

According to the MLC, there are tradeoffs between the two (2) carriers on several benefit provisions, with each carrier having some minor advantages over the other. It maintains with such close bids, this process has come down to which carrier best would serve the City and its members.

The MLC insists, given the acknowledged combined need for quality of care at more efficient cost, it is critical this



systemic change in health benefits go well for retirees and welfare funds, and makes a strong first impression. It argues the Alliance has demonstrated for decades they will do what is necessary to ensure the success of City programs, and the MLC is confident the Alliance will do the same, here.

The MLC urges should this implementation not go smoothly, future efforts to modify other benefit programs will be met with exceedingly more resistance by members and administrators. Another factor the MLC contends weighing in favor of the Alliance has made it clear both Emblem and Empire, residing in New York City, will control the implementation of the program.

For these reasons, the MLC insists the best course forward is with the Alliance, a long time trusted partner. It asks, I recommend the Alliance program.

The City, on the other hand, argues its experts and consultants believe thorough analysis of the final bids demonstrates while selection of either vendor will result in significant savings and would represent a positive step in the provision of quality retiree health benefits, the Aetna bid is superior. The City maintains the primary factor favoring Aetna is Aetna's market share and track record in administering Medicare Advantage Plans.

According to the City, Aetna has been in the Medicare Advantage business since 1986, and has a twenty three (23%) percent

market share. In contrast, Anthem has a four and four tenths (4.4%) percent market share and Emblem has a seven hundredths (.07%) percent market share. The City contends Aetna has serviced large clients such as the United Auto Workers ("UAW") Trust and the State of New Jersey, which are comparable in size to the City. Anthem, Empire and Emblem have no large Medicare Advantage clients, asserts the City. It contends the Alliance is a new concept with no track record and no experience. The City insists experience in providing Medicare Advantage to retirees should be a key factor for the Tripartite Committee to consider.

In addition, the City submits in terms of program quality, the Alliance bid is registered with Medicare by an Anthem Wisconsin plan which has a four (4) star rating but will be jointly administered by Empire Blue Cross which has a three and a half (3.5) star rating and Emblem Health which has a three (3) star rating. The City asserts "Star" ratings determine the revenue from Centers for Medicare and Medicaid Services and reflect the program quality. According to the City, it is unclear, despite the City's questions, how the Emblem doctors would be obligated to respond to the requirements of a four (4) star Medicare Advantage program run by Anthem/Empire.

Also, the City insists while the Aetna bid is premium free to the City for at least the first five (5) years, the final Alliance bid charges seven dollars and fifty (\$7.50) cents per member per

month for the first year, which equates to approximately twenty two million (\$22,000,000) dollars. Moreover, the City contends while there is a gainsharing formula for the Alliance, its consultants believe gainsharing is more likely to occur with Aetna.

According to the City, its experts have determined both final bids are very strong and proceeding with whichever finalist is ultimately selected by the Tripartite Committee is worthwhile. However, it submits the Aetna bid provides a lower threshold to trigger a premium free arrangement for 2026 and 2027, which could be financially advantageous in those later years depending on the experience rating. It insists there is no reason to allocate millions of taxpayer dollars to pay a conglomerate of insurance companies for an arguably inferior product. In all, the City maintains when comparing the two (2) bids, Aetna is more favorable.

As such, it is the City's position Aetna should be designated as the provider for the City's Medicaid Advantage Plan. It asks my recommendation be Aetna as the selected provider.

### Opinion

Both the Tripartite Committee and the Evaluation Committee have worked tirelessly to find the right result. Their efforts are testament to the parties' commitment to finding a solution which addresses the needs of current retirees and future retirees while providing a sustainable income source to assure retirees

receive high quality, state of the art health coverage. One only needs to look at the experience of other municipalities and the threat to their retirees' health promise to recognize how these parties have done it better. They are a role model with how to fund affordable, high quality health coverage.

Preliminarily, I note it has taken years for the parties to have become comfortable with and agree to a negotiated acquisition bidding process for a Medicare Advantage product. For the years I have served as Impartial Chairperson of the Tripartite Committee, I have observed the good faith deliberations on how to proceed. Rest assured, getting to the point of selection from amongst two (2) qualified bidders has been a long, intensely vetted process. Hundreds of hours have been dedicated by professionals, the MLC and the City leadership to arrive at this final selection point.

I also recognize from published reports, and unsolicited communications with my office, this change is the source of considerable anxiety. MLC leadership has reported this fact to me frequently.

Similarly, the City has explained and demonstrated the fact retirees are receiving and the City is paying - directly or through welfare funds - for benefits and products which are not optimal. Simply stated, moving to a Medicare Advantage Program for City retirees is prudent, responsible and essential.

The evidence establishes both bidders would do an admirable job. I am also persuaded when looking at the cost over a several year basis, rather than a single year which I determine would be unwise, there is no material cost difference between the bids. Depending upon reasonable, but not yet knowable, assumptions either program might turn out to be less costly. Thus, the cost of the proposed programs is not an important consideration in my deliberation.

Aetna is clearly more experienced with this product. It is a national company with an extensive, positive track record. The Alliance cannot compete when it comes to experience. If experience was the sole criterion, I would recommend Aetna.

The Alliance has extensive familiarity with the population which will be served by Medicare Advantage. Both when these retirees were active employees, and in their retirements, the component parts of the Alliance: Emblem and Empire, were intimately involved in the healthcare aspects of these individual's lives. Aetna cannot compete with the Alliance when it comes to familiarity with the population to be served by Medicare Advantage. Thus, if familiarity or local knowledge was the sole criterion, I would recommend the Alliance.

On balance, faced with having to choose between two qualified bidders, when the cost differential is minimal, if at all, I conclude - especially for this population and because this is the

first step modifying benefit programs - it is best to select an entity composed of brands and individuals familiar to the participants and knowledgeable about this population which needs to be smoothly transitioned to Medicare Advantage. I conclude this consideration is dispositive.

Therefore, it is my recommendation to the Medicare Advantage Evaluation Subcommittee, and to the Tripartite Committee, and to the MLC and the City, the Alliance be selected as the vendor.

This recommendation is premised on the fact the Alliance has repeatedly assured it is able to operate as a four (4) star rated plan. That is, the Alliance is on notice it is being recommended for selection based upon assurances its lack of experience with this particular product will not be a hinderance to supplying, on any ongoing basis, the product it has promised.

To this end, and this was influential in my thinking, is that the City has other dealings with the constituent elements of the Alliance. If the Alliance is determined to not have lived up to the standards required, the other programs and plans provided to City employees by Emblem and Empire, and its successors or assigns, shall be the subject of a Request for Proposal by the City and MLC when the current plans expire (or earlier as determined by the parties). This thinking has been communicated to the MLC and to the City in the process. It also has been relayed to me the

Alliance acknowledges if it cannot deliver what was represented, here, an RFP for the remaining healthcare programs is appropriate.

One last point. Both the MLC and the City, in this process, have expressed concerns about vendor transparency and their ability to monitor, in real time, rather than just receiving periodic reports, whether any vendor selected is performing properly and/or implementing changes reducing benefits promised or undermining the savings envisioned.

This is a complex undertaking to do such necessary monitoring and auditing. Such accountability requires individuals tasked and dedicated full time to this function.

For these reasons, I recommend up to three million (\$3,000,000) dollars, annually, from the savings generated by Medicare Advantage be budgeted for a Healthcare Compliance Committee ("HCC") comprised of two (2) appointees from the City and two (2) appointees from the MLC. Costs of professionals, to assist the HCC, if any, shall come from this allocation. HCC shall report to the MLC, the City and to the Impartial Chairperson of the Tripartite Committee. The Impartial Chairperson of the Tripartite shall be available to address any disputes regarding the composition, operation and work of the HCC.





# ATTACHMENT C



September 30, 2022

**Via E-Mail and Regular Mail**

Hon. Adrienne E. Adams, Speaker  
New York City Council  
City Hall  
New York, NY 10007

Hon. Carmen De La Rosa, Chair  
Committee on Civil Service and Labor  
New York City Council  
250 Broadway, Suite 1880  
New York, NY 10007

**Re: Health Benefits Matters**

Dear Speaker Adams and Chair De La Rosa:

I write in response to the inquiry of the City Council Civil Service and Labor Committee directed to me as Chair of the Tripartite Health Insurance Policy Committee ("Tripartite Committee") with respect to the proposed amendment to the Administrative Code.

The Tripartite Committee, representing members of the NYC Municipal Labor Committee (the "MLC"), the City of New York (the "City") and myself as Chair, was formed in 2018 to address the delivery of healthcare, focusing on preserving the quality of healthcare of active employees, retirees, and their dependents, while stemming the rising costs of its delivery. This work encompasses a reimagining of how healthcare is structured for City employees and retirees, including redesign of the Stabilization Fund construct. The implementation of a Medicare Advantage construct is but one part of that process, though an important one. A primary directive of the Tripartite Committee has been—and remains—the achievement of these goals without the imposition of contribution to premiums or other significant shifts of costs to the active or retiree communities. This will encompass a long-term rethinking of how healthcare is delivered.

Coming on the heels of an earlier MLC/City healthcare agreement facilitated by me that garnered some \$3.4 billion in recurring savings (the "2014 Agreement"), a second healthcare agreement was crafted with specific agenda items to be considered (the "2018 Agreement"). The 2014 Agreement was accomplished in material part by adjusting co-pays (some up/some down) for active employees to incentivize more appropriate utilization of services (e.g., not using an emergency room where an office procedure is appropriate). No changes were made to the retiree plan at that time.

For the 2018 Agreement, the required savings figure was set at a total of \$1.1 billion. Among the items to be considered in reaching this sum was the adoption of a Medicare Advantage benchmark plan for retirees. See 2018 Agreement, ¶ 5b (annexed hereto). The benefit of a

Medicare Advantage plan is that the federal government provides a sizeable subsidy for having a private insurer administer the program rather than the government. I was kept abreast of the negotiations in arriving at the finalists and in making the award. As part of the process, I was made aware that the bids of both finalists—an alliance of Empire Blue Cross/Emblem Health and Aetna—satisfied the requests that their benefits at least mirror that of the GHI Senior Care Plan, the most popular choice of the retiree community. Indeed, both bids provided benefits beyond what Senior Care afforded. Each of these plans were determined to save the City \$600 million in annual savings for each of the five years of the contract.

As set forth in ¶ 7 of the 2018 Agreement, the dispute resolution clause of the 2014 Agreement, empowering me with jurisdiction to determine an appropriate remedy should savings figures not be met, continued into this Agreement. Here, though the parties in good faith sought to reach the savings goals, the Stabilization Fund, which was to receive the \$600 million in annual savings, does not have the funds to provide the City with the payments needed to realize the required savings. Accordingly, absent a path to those funds, the issue before me in a resulting arbitration would be to fashion a remedy to comply with the 2018 Agreement.

In this regard, the dispute is substantial. As a backdrop to contemplated action, the Medicare Advantage construct is utilized now by almost half of the country's retirees. The proposed Medicare Advantage plan at hand is not a narrow plan of providers but a broad PPO open to any provider that accepts Medicare. It would serve as an appropriate, premium-free benchmark plan for the Medicare-eligible retirees. The MLC Unions very much strove to retain the Senior Care plan as an option for their retirees and negotiated with the insurers and the City to keep it. Recognizing that savings dollars are realized only if retirees move to Medicare Advantage, it was worked out that retirees could remain in Senior Care if they "paid up" for it, with the figure for that set at \$191/month. This sum, it was thought, would preserve optionality while ensuring that significant savings would be realized since most would be expected to be part of the Medicare Advantage benefit-equivalent, premium-free plan.

Judge Frank's recent decision effectively upends the negotiated option. While the Court took the view that the City could not charge retirees for Senior Care (even though retirees for decades have paid up for non-Senior Care plans), it plainly did not require the City to continue to offer Senior Care as an option. The Court acknowledged that the City's obligation is simply to offer an appropriate, premium-free plan—and that would be satisfied by the Medicare Advantage plan. The City does not have to offer multiple plans. Thus, absent the proposed amendment to the Administrative Code that would redress what the Court found missing in current Code § 12-126, I would determine the City and MLC shall eliminate Senior Care as an option. That would, of course, prejudice those who were willing to "pay up" to retain it, but that would in fact drive monies to the Stabilization Fund so that the City could realize savings.

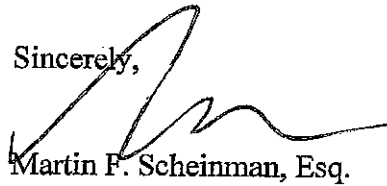
Frankly, the sole available alternative to eliminating Senior Care would be to impose the obligation to contribute premiums. The amount estimated annually is between \$1,250 and \$1,750 to ensure the same level of savings. This premium shifting is something the parties and I collectively have worked years to avoid, as City workers have come to live in a world where their wages are not reduced by having to pay a portion of their healthcare premiums. Doing so will have a devastating impact on those enrolled in the City's health plan including potentially retirees,

and particularly on lower-paid workers and, some of whom would be unable to pay such contributions. Thus, in my view, amending the Administrative Code, supported by the City and the MLC, is in the best interests of the in-service and retiree communities.

I will make myself available to speak with you if you would like to do so.

Thank you.

Sincerely,



Martin F. Scheinman, Esq.

Arbitrator

Chair of the Tripartite Health Insurance  
Policy Committee

MFS/sk

City.MLC.Health Benefits Matters.ltr

cc: Harry Nespoli, Chair, NYC Municipal Labor Committee  
Renee Campion, Commissioner, NYC Office of Labor Relations