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Testimony of James Davis, President
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Before
New York City Office of Labor Relations
Public Hearing on Draft Contract for the Provision of Health Benefits Services in the form of Medicare Advantage Plan
November 10, 2021

I am the President of the Professional Staff Congress, the union representing 30,000 active and retired faculty and staff at The City University of New York. Last summer, as a member of the Municipal Labor Committee, PSC voted against the proposed conversion of the primary premium-free NYC health plan for retirees from traditional Medicare to a Medicare Advantage (MA+) plan.

Earlier this fall, retirees were informed they will have to pay $2,400 per year to retain the coverage they have now (in most cases traditional Medicare plus a supplemental EmblemHealth plan called "Senior Care"), and that they would have to decide what plan they wanted within about a month.

Our retirees have expressed their confusion, concern and anger at being forced to make this decision without knowing whether they will continue to have access to their current health care providers and whether services will require a pre-authorization by the MA+ plan. Significantly, last month, Judge Lyle Frank ruled that it was irrational for retirees to have to make a decision about coverage "as circumstances currently stand" and that NYC and the proposed MA+ plan must cure deficiencies in the implementation of the plan before a deadline to "opt out" can be set. Last week, City Council members reflected their constituents' concern in their skeptical questioning of OLR and OMB representatives about the retiree health plan change.

Now, Unions and their members finally have the opportunity to review the proposed contract between the City of New York and the "Alliance," an amalgam of EmblemHealth, Empire BlueCross/BlueShield and Anthem Insurance Co. of Wisconsin. PSC urges the elected officials of the City to reject the contract because it is significantly flawed. Simply put, 1) the draft contract contains no accountability—no requirement for periodic reporting beyond standard financial and claims auditing. 2) The draft contract permits the "Alliance" to unilaterally change the coverage terms—plan design, rates and benefit provisions—of the MA+ plan, based on federal rule changes, without any consultation with the City or the MLC. And 3) the draft contract does not cure the central defect identified by the Judge - the fact that a large number of health care providers that retirees currently use have not committed to accept the MA+ Plan, which will force retirees to choose between paying $2400 more per year to ensure they can keep their current providers, or potentially suffering a disruption in their continuity of care.

Going forward, accountability is critical. The Labor Management Health Insurance Policy Committee (the City and the MLC, identified as the "Group" in the draft contract) must be able to evaluate whether this shift to a Medicare Advantage plan for

City retirees is providing good health care services for retirees and positive health outcomes, at acceptable cost. To do so, there must be reporting on claims, diagnoses, service utilization, trends, spending, revenues and health outcomes, and the resources to analyze them. The Alliance is required to compile this information and report it to federal CMS which oversees Medicare, yet the contract does not require that the Alliance supply this information to the City or the MLC.[1]

Furthermore, this contract does not require that Anthem of Wisconsin—the sponsoring entity—submit reports which segregate the experience of NYC beneficiaries from any other plans on which they are reporting. Data on NYC retirees needs to be separated and reported to the various parties including the MLC and OLR. The same reporting requirements should be imposed upon EmblemHealth's Senior Care plan so that the experiences of the two plans can be monitored and compared in order to, for example, ensure there is no adverse selection occurring. Without data, the people responsible for the NYC retiree health benefits cannot evaluate the cost and adequacy of those benefits. The MA+ plan customer rating system that CMS requires is insufficient, because it does not provide the necessary cost or quality data. That the City will not pay a premium for retiree coverage under the MA+ plan after 2022 does not mean the employer may walk away from its responsibility for the quality and cost of retiree health care.

This contract must explicitly require consultation and approval from the City and the MLC concerning plan design, rates and benefits, even when mandated by changes in federal rules and rates. But currently it does not include that requirement. The heart of the new MA+ plan is its plan design and terms of coverage. Those in turn are rooted in the rules and payment rates established by the federal government, which can change from year to year. Currently, the contract permits the "Alliance" to change rates unilaterally if so-called "Rate Stipulations" [2]are not met, including if CMS reduces the benchmark rate (the basis for the amount CMS pays the Alliance) by more than 0.5% or if CMS changes its risk score methodology in a way that reduces the CMS payments by more than 2%. The City should not allow this. Both the benchmark-setting process for Medicare Advantage and the risk score methodology have come under significant criticism by members of Congress and the Medicare Policy Advisory Commission.[3] There should be no exception to the right of the City and the MLC to review and approve or disapprove rate changes.

Under the contract, as currently drafted, it is reserved for the "Alliance" to define changes which are in the "best interests of a Member." The contract should prohibit any plan change without the approval of the City and the MLC. For example, it is left to the "Alliance" without consultation or approval from the "Group" to "waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Evidence of

[1] As summarized in a reported from the HHS Inspector General, "Federal regulations at 42 CFR § 422.516(a) establish data-reporting requirements for MA organizations. The regulations specify that MA organizations must have procedures to develop, compile, evaluate, and report statistics and other information to CMS, enrollees, and the public regarding (1) utilization, accessibility, and acceptability of services; (2) enrollee health status; (3) operational costs; and (4) other matters CMS may require." To this list, CMS has added detailed information about medical care denials, appeals, and dispositions.

[2] Contract, p. 227.

[3] MedPAC Report to Congress, Medicare Payment Policy, March 2021, pp. 356-7. http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf

Coverage . . ."[4] Why should the City and unions be concerned? A simple example is that the draft "Evidence of Coverage" which is appended to the contract indicates the likelihood of extensive pre-authorization requirements for services, including physician office visits, all labs and x-rays and almost all rehabilitation services, as well as inpatient services, outpatient surgery and durable medical equipment, belying repeated verbal assurances by the "Alliance" to retirees that pre-authorizations will not be more extensive than they are currently under Senior Care.

Finally, the contract must contain assurances that retirees will be able to keep their current providers. The Judge noted that many retirees' physicians told them that they would not participate in MA+, and this was the core "defect" he directed the Alliance and City to address. The City's affidavits purporting to solve these defects, submitted this past Friday do not provide any certainty that retirees will be able to see their current providers. Absent such assurances, thousands of retirees may well suffer disruption in their continuity of care.

[4] Contract, at 13B.