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Myths and Facts about NYC Employee Health Insurance

New York City plans to announce a new health insurance plan that will replace current plans that cover active employees, retirees under age 65, and their dependents. Expect a major change.

As soon as the contract for the new plan or plans is available, the PSC leadership and health team will provide you with as much information as we can about the details. But even before the new contract is made public, you may hear claims about it from the mayor's office, other unions, and the media. The PSC leadership wants to help you sort the myths from the facts. The overview that follows is based on the PSC's analysis of the economics of NYC health policy and the cost-reduction strategies that have been publicly discussed.

Background: The City's Goal

CUNY employees and retirees are covered by the NYC employee health insurance program, which costs about $9.4 billion per year. Roughly 70% of those covered (active employees, pre-65 retirees, and their families) are covered by the "Comprehensive Benefit Plan" (CBP), more commonly known as GHI and Blue Cross. For the last 18 months the City administration and the Municipal Labor Committee (MLC, a coalition of the municipal employee unions) have been soliciting bids from insurance companies to replace the current Comprehensive Benefit Plan. The intention is clear from the City's own published request to potential bidders:

> Our joint goal of the redesign is to reduce the cost of delivering healthcare by at least 10% while continuing to provide efficient, high-quality healthcare to all City employees and pre-Medicare retirees without significant increases in member out-of-pocket cost. (RFI 6/10/22)

The goal is completely unattainable. It is impossible to cut $1 billion from the City's annual spending without reducing access to medical care and/or shifting significant costs to the plan participants, NYC workers.

Details of the new health insurance program have not yet been made public, but we can expect it to be introduced with great fanfare and a number of broad promises. One aspect of the new plan will remain the same as the old one, at the insistence of the MLC unions: Employees will still not have to pay a monthly co-premium for health insurance.

Myth: NYC workers are the beneficiaries of very expensive health insurance.

Fact: The amount the City (including CUNY) pays in health insurance premiums is comparable to other plans. In fact, the cost to the City of the CBP is on the low side, compared to other private and public employer plans, considering that the cost to employers for health insurance in New York State is the highest in the country. CUNY employees covered by GHI know it is adequate coverage for outpatient doctors and services, but not "generous." Some GHI participants may (and are financially able to) see a doctor not in the GHI network by paying the difference between the doctor's charge and what GHI reimburses. Others work hard to find a doctor who accepts GHI's reimbursement. Blue Cross hospital

coverage has also been adequate, and—importantly—allows access to almost all the hospitals in the NYC area and covers most costs.

Myth: Your co-pays and deductibles will not increase.

Fact: Under the new plan, it is likely that many hospitals, doctors, and other outpatient providers will be "in-network," but there will be different levels of cost to the patient. The hospital network will almost certainly be "tiered," meaning that the cost to patients will be higher at the hospitals that charge the insurance company more. It is likely that the current annual deductible ($200/person) and copay ($300/hospital admission) will remain the same if you use a lower-cost hospital like Bellevue, Lincoln, or a select group of private hospitals. Other hospitals will still be in-network, but if you are admitted to the most expensive ones, like NY Presbyterian or NYU-Langone's Manhattan campus, you will likely have to pay a larger deductible and/or copay.

The same principle applies to primary care doctors and specialists. Currently, the GHI doctor network is very limited and has low co-pays except for Advantage Care clinics, which have no co-pays (another form of tiering). Everyone is charged a $200 deductible once each year under the current GHI plan, and then, if you see a non-GHI-network doctor, you pay the difference between what GHI reimburses and what the doctor charges. The new plan is almost certain to cost more up front for a non-network doctor, but the outpatient provider network may be larger. And the annual deductible for outpatient care as well as copays for in-network doctor visits may be increased. Additionally, the standard for total out-of-pocket expenses incurred before insurance pays 100% of your costs is likely to increase from the current $2,600 (individual) and $5,200 (family) to a higher number.

Myth: All NYC hospitals will be included.

Fact: All NYC hospitals may be in network, BUT, as explained above, there will be different out-of-pocket costs depending on the hospital you choose (or to which you are referred). Your family's income will be a key factor in determining which hospitals and doctors you can afford to visit. If one of the higher-cost hospitals becomes unaffordable to your family, you may face having to change doctors to a doctor linked to a more affordable hospital.

Myth: Your doctor is the one who decides what care you need.

Fact: The insurance company is likely to impose more requirements, such as needing to issue prior approval for expensive services like inpatient hospital care, rehabilitation services, or high-tech imaging. While the current CBP insurance companies already reserve the right to reject a doctor's recommendation, they rarely do so. Because the City is demanding that the new insurer reduce the City's costs, the belt will be tightened. You and your doctor may need to go through more hoops, and some requests may be denied. The PSC will be calling for a robust appeals process in whatever plan is selected; participants and doctors need to be able to appeal denials of care.

Myth: The new insurance plan can save money by paying providers less than they are paid now, but the quality of care will not be diminished.

Fact: Even a purchaser as large as the City of New York, which covers one million people, does not control hospital pricing. Hospitals and insurance companies negotiate how much the insurance company will pay the hospital for each type of care. Different insurers reimburse differently. (For example, contractually agreed-upon payments to hospitals and doctors for routine maternity care and delivery can vary widely from insurer to insurer and from hospital to hospital.) City workers are a small subset of any one hospital's patients, and the hospital will be paid what they negotiate with each insurance company, whether the patient is a NYC worker, or someone covered under a different plan. What might be different is how much of the bill falls on the patient. If the new City plan pays hospitals a smaller share of the agreed charge, the patient will have to pay the provider more.

Myth: Employee health insurance costs are a significant element of the City's budget, and costs have risen so dramatically that there is no alternative to negotiating for a plan that costs less.

Fact: It is true that health costs nationally and in New York have risen dramatically, but it is false that the only way to approach the problem is to shift costs to workers or reduce care. There are several different steps the NYC administration could take to reduce costs. First, NYC government should have a health insurance policy office to design and monitor benefits that better meet the needs of its employees rather than depending on an insurance company to do so. Under "self-insurance," the City would be directly responsible for plan design and paying medical expenses for City employees and their families. It would contract with an insurer to take advantage of their discounts and to process the claims. Self-insurance allows flexibility in what is offered to employees. Further, it could save 1-2% or more, some of which should be invested in a professional office to manage this work. The City should aggressively monitor claims payments to minimize fraud and overuse. The "self-insurance" approach is preferable to the current scheme where private insurance companies design and implement health benefits with their bottom line in mind.

Second, and most important, NYC and the municipal labor unions should use their considerable political muscle to pressure NY State to implement programs to control health care spending, as a dozen other states have done. One way the State can control hospital prices is by enacting legislation to require all-payer (government and commercial insurance) reimbursement rates for hospital-based services, like the program that existed in New York from 1978 until 1996. There are other approaches, including capping annual increases and establishing global budgets, to develop a fair and controlled system to replace the current crazy patchwork that rewards the richest and the most opportunistic.