Municipal Labor Committee Meeting on Health Care
September 10, 2025, 9-11am
125 Barclay Street

Alan Klinger [MLC Attorney]: As part of Segel's presentation, some of the questions really don't go to this health plan. I just wanted to get how of the way to start. People asking about stabilization fund. The whole idea of the negotiated acquisition is to move away from the construct of the stabilization fund that is limiting our ability to make changes, to do efficiencies, and frankly, it was creating wrong incentives for the carriers, you know, and for us. So the stabilization plan is not going to be continued, so that is, an answer to, you know, one of the questions that that are out there.

And so, and then this morning, we see that Athemn is running a piece on NY1, saying, you know, it's not necessarily a done deal, that we're switching the providers. You know to now, it's in joint venture of Emblem and United healthcare as opposed to emblem and empire Blue Cross. One of the things that people have asked about, which is going to be part of Segal's presentation, is that this is a far more unified structure. It's often going to be of a unified platform, a unified administration implementation, Kristen Len can get more into that, but that's one of the way they're saving, and it's an improvement, but also anthem is speculating that you're not going to have the same doctors, you're going to hear and see, you are having the same doctors. Not only are you having the same doctors, your pool of providers has greatly expanded, particularly for pre Medicare retirees.

Those who live outside of the New York Metropolitan area, one of the issues that people have had for a number of years, which we understood and we were pressing to expand the pool and providers for particularly Carolinas, Alabama, Florida. We agree, we understand that there was a dearth of in-network providers, that has changed. And so I'm not exactly sure what happened is relying on or saying that you're not going to be able to get the doctors. It's just not right, and you're gonna see where the material here.

One of the lessons that we learned from Medicare Advantage is to make sure that right up front, not only do be members, but the health care providers have to know about this, need to know about this, because what had happened with Medicare Advantage is that there was a new name that was constructed for the program. People thought that was a good idea to show that it was different. It turned out not to be such a good idea, because when people call the doctor offices and the front office staff, they didn't know about it. So they just said, no, you're not covered. We're not part of it, even though they were. We learned from that.

And so the minute that this ultimately gets ratified, assuming that is the case by the MLC, which, for your planning will likely be September 30, Emblem need to meet with these go over some stuff with the executive board and make sure things continue the next two weeks, but that is right now, the target date. Once that ratification is done, Emblem + United Healthcare have materials all ready to go out to their networks of providers to explain it to them. You're going to

be able to have members go on–I'm not sure I actually know what a microsite is–but apparently you're going to be able to go on a microsite and be able to check yourself in addition to calling, to being able to you know, reach out directly to your providers. But that was a lesson learned. We're set for all that to take place. So the people who worked on this, so far, you know, people from, you know, Segal, from the MLC, UFT, DC 37, very much involved, that you know, we think that we've been able to produce a very strong product. We hope you agree at the end of today.

So I want to turn it over to Chris and Len to sort of get into the sort of part of the actual plan.

Chris Caller (Segal consultant): Thanks, Alan. Good morning everybody, and actually at this point, know quite a few of you, but I'm Chris Caller at Segal, my colleague, we've been working first–don't hate us–for the city for a number of years and actually for the MLC for about 15 on these plans. So we are pretty familiar. It's been 25 years of both sides of the table for us. I can say I was thinking this morning, this me, honestly, in my view, be the biggest accomplishment I've seen in 25 years. But I am not here to sell you on that. I am here to educate you, and hopefully we do that today.

So, this, for all reference, is the same presentation you were all sent. There's a couple little corrections adjustments, nothing that's material, I promise. But we thought we just walk it through again. First few slides, very quickly, you know, the reality is, you've been having trouble with the network. You've been having trouble with behavioral health doctors and finding them. Your people have been frightened with copay increases, and frankly, over 10 years, the cost of this plan has doubled. So that's what got us here. That's what drove us to do and negotiated acquisition, I'm sure you all have heard this term by now. You know, it's a RFP for those of wondering what an negotiated acquisition is. It's just, in a way that allows the city to actually negotiate more than the strict rules of an RFP, which are a little, you know, they're more confined in what they can do and how many times they can go back to a carrier or a bear. So we went through that process, as most of you will remember, we chose finalists. We chose finalist a few years ago, and then awarded the business, you know, primarily to, not primarily, initially to envelope in United Healthcare, subject to negotiation, and that took place from the end of May, through a week or so ago. Okay, so that's where we did a lot of the things you're going to hear about in eliminating some of the things you may have heard about before then, tiering, lots of prior authorizations, all kinds of changes. All those were in the bid, okay? So we don't want to say, you were never there. A lot of them were eliminated over the summer, successfully, and so that's an important point to know.

So, again, what are we accomplishing? We're keeping the network and expanding it. So if you are in the downstate 13 counties, right, the counties in New York, you think of, New York, Nassau, Suffolk, Rockland, etcetera. The Emblem network is going to remain the network. It is expanding, okay? There's an Emblem health network, and then there's an emblem Health Bridge network. Today, you members are in the Emblem Health Network in 2026, they will go to the Bridge Network, which is bigger. We'll touch on the statistics on that in a little bit, but it is bigger, okay? Outside of the downstate 13 counties, and importantly, this isn't just retirees. It's

folks in Connecticut. It's folks in New Jersey. It's folks in Pennsylvania. Okay? The network expands and becomes the United Healthcare Choice Plus network, okay?

And we'll talk again about what that means, but I want to say this up front. While we're gonna wait until ratification, if you want to know or your members want to know, if their doctors or providers or in network, they can do that, okay? They can call their doctor if they're in the dance 13 and say, "Are you in the emblem Health Bridge Network?" Okay? If they are outside the downstate 13 counties, they can ask if their member is in the United Healthcare Choice Plus Network. Okay? Those networks exist today. They're not being created for this. So they will - doctor's offices should recognize those terms. Of course, once ratification happens, there'll be a bigger campaign that'll talk more about the New York City PPO Plan etcetera. But if you want to check today, they have, right?

Benefits are maintained, There are some enhancements to care management to be a real health network, etc. Access to mental health changes dramatically from the Carelon network that we're using today to the United Behavioral Health Network. Okay? Dramatically, and again, we'll show you some of the statistics. Importantly, everybody's going to access, be able to health care through the United Behavioral Health networks, some of the questions we got were, are there two behavioral health networks, are there multiple, depending on where I am, nationally, we're going to be using the United Behavioral Health Network.

We are not changing co pays, okay? We'll show you, all of you received a chart, we'll review it again today. That shows you where the copays were and all the plan design elements were today and where they are in 2026. The only color you see on that chart of any change is green, okay? So nothing is changing negative, if if it's not on there, it's not changing. There's only so many pages where we're going to go through. But your tenet is nothing is changing unless it's specified on there.

And as has been said, this locks in premium free healthcare, you'll know that the stabilization fund, help cover the additional cost of the CVP plan over the HIP rate, right? So when the stabilization fund went into a negative, the city naturally was really pushing for the unions need to cover that money. And we used to use the stabilization fund to do that when there's no stabilization fund. The city's obligation is still the HIP rate. So what we get here is get us, get a commitment that we will not be your members will not be paying the additional cost between this plan and the HIP plan. Somebody asked them the questions we received, is the rate higher? The answers yes. This plan is still more expensive. It's meaningfully less expensive than the CBP brand, but it's still more expensive than the HIP plan.

So you all know this timeline, you know, we've said it all for years, summer, we're here now, we're gonna hopefully answer questions today. You're out here today so we can answer your questions. And then the plan again as Alan said, is, to vote, to ratify on the 30th.. So that's how we got here.

Let's talk a little about what this plan is, okay? So, as I think you'll know by now, this plan will be administered by a partnership between Emblem Health and United Healthcare. Okay? There are distinct roles of each. There are parts that getput together. We'll talk about that, but just up front, understand, this is no longer what we've call for years a bifurcated program. This isn't two cards for your employees and members. This is not, you either call Anthem for your hospital problems, or you call Emblem for your other problems with providers. This is true. This is going to operate as one cohesive plan. When that happens, in the downstate 13, no disruption, okay? Again, it's the emblem network that you had today with some expansion. On the facility side, where it was Anthem, we've confirmed with United that all of the facilities that were in the Anthem network in that downstate 13 are also in the United Healthcare Network. So the big five families of hospital systems are all in, the main facilities are all in. There should be no disruption in the downstate. And out of that area, again, will be dramatically improved.

Other Segal Consultant: In emblem, in the downstate 13, in United Healthcare for outside of the 13, just to mention about the hospitals, that the hospitals are the same with Emblem in the downsatet 13. So emblem covers the entire program in the downstate 13; UHC outside.

Chris Caller: Okay. Um, we'll get to some statistics to back these up. But, again, vastly improved behavioral health network and providers, some people said is that all virtual, the answer is that resounding no. Okay, we'll talk about that, but it's not just now you can call people virtually for behavioral health. There are vastly improved, in-office, opportunities for behavioral health.

We started this summer with a very long list of prior authorization procedures. There is still a list of prior authorization procedures. It's about half of what it was when we started at the beginning of the summer, and the important thing there to understand is the United healthcare and Emblem made some commitments around a trend and the ways to control trend and the cost year over year in this five year contract and they are standing by those, despite the fact that we've significantly reduced [unintelligible] burden that was originally in the RFP. We're not doing tiering, and the prior authorizations are frankly, much more intelligently designed. It's not all the old ones. We took a very good look at it to say, you know, where is it actually appropriate to do prior authorizations today, and where are you awarding 100% and just putting, you know, roadblocks up that are not valid for members. So the numbers drop dramatically, but the commitments by the carriers and the trend guarantees are still in place.

And again, I think Alan mentioned, we have these two centers of excellence, Memorial Sloan Kettering and Hospital for Special Surgery. They're hallmarks, the entire group is proud of those, they are remaining. They are still free to members to utilize, they have agreed to transfer over to the Emblem network. They were in the emblem network, but under this construct of the CLE, also the ACPNYs for your members to utilize will remain free and in addition, which is not on Health + Hospitals corporation physicians and facilities move into zero pay healthcare.

Henry Garrido: Before I interrupt, I just want to make sure we're clear about this, that rather than impose a tiering that would increase money out-of-pocket for members, you, we're going to, you know, we talked about Presbyterian and all that stuff. That is, for the members who want to use the Health and Hospitasl, the co-payments that are currently assigned would actually decrease, which is an incentive to use it. You don't have to if you don't want to, but if you are using it is actually copay for the decrease for the out of pocket.

And I think from a perspective of the union that represents members there, that's a big deal given the federal cuts and should be a big boost for HHC.

Chris Kollar: I want to spend a few minutes on the way this is constructed, okay? Again, from questions we received, this program will run on a United Health Care platform, United Healthcare will pay the claims for all members nationally, okay? The Emblem Health contracts in the Downstate 13, both the hospital ones and the provider ones, will be loaded into the United healthcare system. They will do the initial claims payment that care management programs that will occur will all be United Healthcare's programs for all members nationally. The difference is that in the downstate 13, those programs will be administered and done by Emblem Health employees. The idea was simply: Emblem Health employees know your people. They know your area, they understand the marketplace. So they're gonna be the ones taking the calls, making the end of the calls in the downstate 13,

Nationally, it will be both the care management standards from United, and they will be run by administering the phone calls, etcetera will be handled by United. But again, the network is the downstate 13 is Emblem for doctors and hospitals. In the Downstate 13 and nationally, Behavioral Health Network is united and all across no difference. And then outside the downstate 13, the network for the United Choice Plus. Okay, but that's the kind of bifurcation of duties. Emblem will still be doing the contracting in downstate 13, if you called United Healthcare and said–not that I would do this often–how you doing with your Memorial Sloan Kettering contract? They would say, "I have no idea. It's not our contract." You know, it's the Emblem contract thatis going to the facilities, the doctors, et cetera, in this downstate 13. Sorry, just making sure I'd covered everything.

Um, we touched on this and that single ID card. There will not be multiple ID cards as it is today. They will say NYC PPO on the back, it will tell them where to send their claims again, everything's going to the same place. So that should be handled properly. There will be one website, one member portal, etc. so that things that a lot of members experience today should get simpler.

And the one thing that you'll notice here is because we are now jointly administered a single place carrier system, the out of pocket maximums in this plan are combined. So if you looked at the plan design today, okay, the out of pocket maximum, meaning the absolute most that a member can spend today was split between –sorry these are rough numbers. Sorry, I can't remember. About 4,000, 4,500 or so. 45, 50. Yeah, 4550, Okay. And the other 2650 or 2050 was on the other side hospital doctor, okay? The reason we had to do that is because Emblem and

Anthem couldn't tell how much was being spent on the other side. We can now tell that. So going forward, we actually will combine that number, but that's the change there. So I want to be up front. That is a change, okay?

Unidentified questioner: But the aggregate remains the same, correct.

Chris Collar: The amount remains the same, the way it's administered is slightly different. Okay, let's talk about the provider networks. You know, there were a lot of questions on this. We'll try to incorporate them. If not, it's raining outside. I don't want to go out anyway, so we'll be here a while. So in the downstate 13, again, there are 78,000 providers in the Emblem network, okay? That's the Emblem Bridge network? That's what I mentioned is the new network we're moving to. That is up from the CBP count of 64,000 providers. The difference is we're basically moving onto an emblem standard network. For those of you who may remember, the City has said its own fee schedules with emblem for many, many years and over time, doctors dropped off. So now we're moving to an actual emblem standard network, the bridge network. All the doctors that were used prior are still there, all the hospitals are in this network, but it expands a bit, right? I mean, pretty meaningfully another 12-14,000 providers. And in the contract, emblem has committed that number will not drop below 74,000 providers.

We did ask Emblem how many of those are available and indicated as open panels. 97% is what is the answer they got. For the plan administrators in the room, I would take that number with a slight grain of salt if I'm trying to be honest with you all. But that is the number that was reported. We all know that it's difficult to keep that number current at all times. But that is the number that Emblem reports to us. Okay, 97% are open panel doctors and facilities at this point.

Out of the downstate 13, nationally, this is where the dramatic change happens, okay? Today, there's about 120,000 providers. The reason that's not couched as an about is–you might not be surprised–Anthem wasn't all that giving their data to us during this process of getting ready for these meetings. So we estimated that one. But together, the anthem and emblem networks outside of the downstate 13 represented about 120,000 providers. The real reason for that is that Emblem was managing that out of area network, and they basically were more of a triage unit, where they saw a lot of use, they would go and try and get a contract, okay?

We're moving that to the United Healthcare Choice Plus Network. It's a national, established, there are millions of lives on this, and what that does is allowing us to go from 120,000 providers to 1.6 million providers. Now, that's about 600,000 doctors. Then there's, you know, therapists, specialists, etc. all kinds of ancillary providers. So you know, that number is comparable to all the other national networks. You know the big four–the Cignas, the Aetnas, you know, But that is that's how that is moving so dramatically, is we're actually moving to a network is more ,put it loosely kind of a triage unit that Emblem was using to get to claims when they came in.

What that means is the top 16 states right now, as of 2026, we'll actually have more than 500,000 doctors in the network. Again, that top 16 includes New York, obviously, but there are,

you know, the network of numbers change dramatically on that, on, you know, inside a bit, but outside, very dramatically. Again, we think that's gonna be a real vast improvement for people. Um.. I mentioned earlier, there are commitments in this contract. Um, to maintain these networks. So it's very nice for them to say, "We're gonna have this," but if, you know if costs increase, we see them potentially slashing their pay, their fee schedules, and doctors leaving, we don't anticipate that, but we haven't, you know, healthcare is a very complex system, but what we have from the carriers, Emblem and United, commitments that 90% of all services at a minimum in the downstate 13 will be in network. 95% of all services outside the downstate 13 will be in network. So these are comparable, by the way, to the standards that we saw when we did the RFP, when we matched up the service counts, when we made sure, and did the financials based on what was going to be in network and out of network.

So these are not numbers that were just kind of created. These are valid and based on what we expect the providers to be providing and the standards they should be performing to. And they also are very open to any doctors that we feel should be in network that are not. They want to recruit them. Emblem in particular, is very excited about having the power of he city's membership, to go and do that and to work with us. I think, United Healthcare and places like Florida and North Carolina will pick up a bunch of retirees in New Jersey, you know, lots of members there. So this gives them buying power if you will, with providers, that they are happy to try and utilize and getting that network even broade

Okay. Um, let's talk a little about the Behavioral Health Network. So, um, yeah, you've seen these statistics by now. In New York State, again, don't be thrown, down there in New York State. Different networks kind of measure and count things a little differently. The behavioral health network reports by state, so that's the numbers we're using. The current New York State under Carolen is about12,000 providers, that will go up to 39,000 providers under the United Behavioral Health Network. 87% of those are accepting new patients. If you know, I'm sure many of you have heard the challenges of mental healthcare, the number is almost guaranteed to be a little lower around accepting new patients on mental health, but 87%'s a very meaningful number. New York State again, they have committed in the contract to not let that number of providers drop below 39,000.

Another question we got is, does this mean that we want from 12 to 39 by just adding a bunch of virtual? Absolutely not true, right? Over 32,000 of these are in-person providers. Many providers today, to be clear, are what we call hybrid. They do both in, you know, in-person and virtual. That's just what happened out of COVID. But the network itself is vastly improving and many, many of them–the vast majority of them are available both in person and virtually. Nationally, the numbers are even greater in terms of increase added in 61,000 under the current Carelon provider network that will go to 413–I'm sorry, 418,000 providers under the Behavioral Healthcare Network, getting similar numbers, 84% nationally are accepting new patients, similar numbers in terms of 85-ish percent of those are happen in-person an addition to a virtual. availability. And combined what they've committed to is an 86% in-network utilization, okay? And again, compared to I can't quote for you right now, the number, but compared to today, and

compared to the challenges we see around getting in-network behavioral health care, 86% is a tremendous number to get up to of the services will now need a number

So there are a bunch of virtual healthcare options being added in. You know, Charlie Health is actually a terrific program. I used it with my children. Hazel and Betty Ford for substance abuse, in stride is another one, talk space. So the great part of these, I know there's always naturally some suspicion around virtual, typically numbers can get in quicker, they can get care quicker, they have resources that they can trust when they have a problem, and if you've ever had a mental health challenge, you don't know when it's coming, and when it comes, it comes fast. So being able to have more resources in this area that people can access completely, we expect to be a terrific enhancement for people.

Other Segal Consultant: So there is a significant improvement in terms of number as well, there's 22 different specialty providers in that space going forward, up from seven, and they cover a vast number of different specialties within the behavioral spectrum. So, you know, as Chris was mentioning, one of them might be for OCD, another one might be for teens and adults and anxiety. And so there's a host of different ones that will directly through the concierge.

Chris: Um, we mentioned this earlier, but here again, little deeper, a little more on the numbers. Um, prior authorizations, right? I've read about them in the papers. You've heard of them from your members. They're sort of the bane of the healthcare world these days. Where we started in this process was there would have been nearly a million prior authorizations, we would have expected in a year. Where we landed is that there will be 461,000 less prior authorizations in a year, so about half will be dropped off because we did a we took the hard look with the help and the agreement of United Health Care and Emblem at their prior authorization procedures and what they expected, and there were a number of them that, frankly were just unnecessarily roadblocks. They were either always approved or always in, you know, it's just they were not, not only member friendly, but they were not effective. So those have been removed from the list and from the program that will take place in 2026.

Things like MRI, CT scans, some orthopedic surgeries, are going away. Now, I want to be clear. It doesn't mean you're never gonna need prior off for an orthopedic surgery. There are things like that where they may want you to still try, you know, therapy before you. So I don't want to present this as there's not, okay, but it's much more appropriate now. It's the stuff that was just there and kind of legacy from a program that's 40 years old, we haven't bid this program in 40 years. Okay. So that stuff is being modernized, if you will, and upgraded. And there will still be times when people should be checked, right? We still need to manage the cost of this plan. But generally speaking, the ones that were just roadblocks and antiquated, etcera, have been removed.

Alan: And Chris, if we can. In the downstate 13, the prior authorizations are, where the funding administrators know that if they have concerns or issues they't work through, emblem is there for that, so for downstate 13, this procedure is through Emblem..

Chris: Right.. As we said earlier, the standards will be, OK, the United Healthcare standards, so every member is subject to the same standard, no matter where they live. But for downstate 13, they will be reviewed and managed by emblem, which we all know. And feel is important for this.

You may have noticed, and some of you asked questions around this: There will be a new MLC OLR-Review Committee,Ookay, to be clear, this is not the monthly joint MLC committee. This is gonna be a very targeted committee that both MLC members, OLR members, Emblem, and United Healthcare, frankly, to check on all these things that I've just had the nerve to tell you about. You know, are we tracking at 90% of in-network service? Are we hitting the goals and the standards that we're all expected and that are in the contract?

Where are we with, you know, the hospital contracts, which remain an important part of this, right? Not tiering, okay? But where are we with achieving those goals of getting better hospital contracts? Where are we with making sure that the provider networks are at the standards that we want, and reviewing how PAs are working, appeals are working, et cetera. Importantly, at an aggregate basis, okay? This is not a committee that's going to hear individual appeals, they are not going to look at members, but they are going to look at data monthly to make sure this plan is tracking and where it's not tracking, the contract has built to it some quick expedited mediation and review procedure. So if the city and MLC believe that the plan is not tracking where we want and United and Emblem, say, yeah, it we'll figure out. There's procedures in place for that, okay? One of the things we really want to do is be able to keep up to speed on this, and I quickly, especially when it comes to the hospitals. They need to be aware that we're watching them, right? So that's the goal of this committee.

I know some of you asked when it starts, how often it meets, who's going to be on it. It starts as soon as this plan starts. I believe, I'm not sure it's, again, smaller, it's going to be five or six members, same number, MLC, OLR, MLC leadership will point those that hasn't been done yet. And the intent is for that committee to meet monthly, and this does not replace the joint MLC. I think the expectation is that this committee will report out to the MLC. Monthly, the same way the PICA committee does, the same way, the audit committee does, et cetera..

Henry Garrido: Yeah, I think it was important for us to keep a certain level of control, right? We didn't want to have you people pitched to you a new product and tell you that the best things since sliced bread, and then, excuse me the shit starts happening, right? Things start going. We want to have an opportunity to go back, and it may be, have the opportunity to normally apply, but oppress all those issues, if, in fact, some things will come up, not just on denials, but in anything. And one of the concerns that we have is that we in fact, in this process, we feel we have more control than we have before, with Anthem, because every time we went to an Anthem was like, well, tough, this is the way it was, right? This establishes a new opportunity for us to do and intervene when necessary, and individual unions can bring stuff to the MLC as we move forward.

Chris: It's might be a good, I don't have a slide on this, but there were a number of questions we got around–okay, so this is all wonderful, but somehow it's been to save a billion dollars at

the same time. I've heard you guys before. So let me just cover that briefly, and I put it here on because that's part of what this review committee's gonna do, right? Is they need- there are expectations, there are lots of details and statistics around how this billion dollars is supposed to get met. And this committee is going to track that as part of what they're doing.

So there's really four or five big buckets to these savings, right?

There's about $400 million of the billion that comes from improved networks and discounts, okay? So keep in mind, there's very little actual network outside of the downstate 13 right now. So when we capture all that in the United Healthcare network, that will do some of that number. We're also improving the network within the downstate 13 from emblem. And we're getting emblem's hospital contracts instead of Anthem's. So, the estimated, again, these are not numbers that were taken lightly. This was Segal and Milliman spending, frankly, three years looking at what the carriers were putting forth that will save roughly 400 million by moving to those networks.

There's another 300 million based on some of the things we've talked about already in better plan management, okay? This is going to be one plan, okay? Which means that the hospital people and the hospital managers will know what the doctors are doing. The doctors will know what the hospitals were doing. They will both be able to see the drug data that comes from the riders and the people plan, et cetera, okay? So there's a lot more that they can do with that knowledge, especially for those some of you who know this. When they can get drug data, they are able–drug data is typically the first plane that comes through, right? You go to a doctor, you leave the doctor with a prescription, you go to a pharmacy, the pharmacy puts that through, and it goes all the way through to the provider half hour after you left the doctor. The doctor claim even for an office visit, it doesn't typically get to the carrier for a week or so. So the fastest way for them to intervene is to have the drug data, and they will have the drug data in part because of this better plan management, because it's all under one system. So that better plan management also allows them in one system also allows them to look closer for fraud or abuse. Okay? Today, somebody might bill emblem and also bill anthem. And there's basically no, you know, there's no connection to make sure that's not happening tomorrow in this new plan. All those claims are sitting on the United Healthcare platform, and they can watch for those. Okay? So that number around better plan management, which spent of the broad number is 300 million?

The next one is important. I believe it's been raised before, but let's be on front about it. There's $100 million dollars expectation around savings from the Emblem United Healthcare Plan getting welfare fund drug data. Okay? There are confidentiality agreements that have been drafted. There are standards that will happen. This data will not go to the city, it will not go to the other unions. It goes from your PBM to Emblem, and United, I want to be clear, this can't be de-identified, right? They need to be able to match it up with their medical claims data, with the data they have, so they can manage patients. But 100 million dollars is the expectation. They feel they can achieve more savings if they have that data.

There's $25 million around improvements in pricing for the drug rider and the diabetic drugs with Emblem moving their PBM from ESI to Prime, okay? When they did an RFP, they moved to Prime, that is happening 1/1/26, no matter what we did, that was going to happen. We did get some questions: is the senior care under Emblem also moving to prime? The answer is yes. Okay, that was an Emblem decision. They are moving their PBM. So that will happen, but there's about $25 million in savings we expect of the plan.

There's $50 million in administrative savings, so, you know, moving from this bifurcated two-system, two-carrier system to one carrier is expected to save about $50 million in admin fees. That one's actually pretty solid, right? We know what the fees were today. We know what they're gonna be tomorrow. So there's $50 million between the fee reductions and the combinations and some of the credits that have been built into the contract.

And the last is about $200 million, possibly more than they say, possibly because this is still being negotiated, in city specific contracts. So emblem is going out to the major hospitals and looking to establish different, better contracts only for city members than they have for the rest of their population. Again, that is starting, that is a goal. It will take place and will be monitored, but that is not we can't put an absolute number around what's been achieved there yet, because that is in its initiation, okay? But that is happening as we speak between Emblem and the hospitals.

Okay. So if you were keeping track that actually adds to a little more than a billion, but it's, you know, some of these will, honestly, there's what we'll do with the joint committee. Some will be a little higher, some will be a little less. We've got a little cushion, but that's the expectation.

Um, other things that are happening are some improvements in what's available and care management. And again, they all know care management is not mandatory among the city employees, this is not, they're not going to be penalized if they don't participate. That's really important. That remains true. But what is happening here is we're adding a lot of the same standards that you may know from the HIP plan. If you remember, a few years ago, the HIP plan at what they called well spark programs and abilities. Many of those programs are being added here. So if you have hypertension, if you need home healthcare, even oncology, there's going to be many more opportunities for you to work with nurse care managers, people to help you, they will identify based on the data and reach out again.

Remember, I chose to participate or not, would encourage it in all these areas. So there's some of this in the plan today. There'll be much more of it going forward available to members, not mandated to members. And we mentioned this earlier, but it's worth mentioning again. The zero dollar copays that you all know at ACPNY and at Memorial and at Hospital for special surgery, also now it's banned to the Health and hospitals Corporation. Okay, so when we bring up the plan design document, you'll see some green charts, a lot of that is simply you get to get zero copays now at the Health and Hospitals corporation.

Brian: On the slide provided, chiropractor is at the bottom?

Chris: The reality is New York Health and Hospitals doesn't have chiropractic, so if they did, it would be zero, but they don't, so we took it off the line.

Henry Garrido: And just clarification for urgent care, right? Although the copays is zero at HHC, the copay for urgent care goes from 50 to 25. Yes. And so there is a co pay for urgent care at HAC.

Donna: Excuse me, Urgent Care is still- don't we have that one?

Alan: For urgent care, if it's at Health Hospitals, it's 25. If it's in network, in the downstate 13, it would be $50. But there are some preferred and non-preferred, so there are two kinds of providers that would be at $100 copay, which is currently the way it is today. That's with Pro-health and City MD.

Henry Garrido: So it's going to go to $25 HHC and $50 ACP, right? So it is going down, not just for HHC.

Donna: Yeah, because there are an awful lot of people who complain about City MD not to having the $100 copay in it. So that's a big issue. And I know that it previously that they negotiated, they were negotiating with them to bring down the cost. So they weren't able to get a better negotiated rate from-?

Chris: In the end, again this played out over a period of time, we did at one point and Donna, you were were probably at this meeting, hear that they had negotiated a better rate with City MD and several months later, we heard that City MD backed out of that.

Donna: Okay, is it still ongoing? Because we have an awful a lot of people who use that fairly. Especially in Nassau County, those are the prevalent urgent cares. They're all over the place, so a lot of people go to them. Are you still currently negotiating, trying to get them back in the network at the, you know, at the $50 co pay rate?

Henry Garrido: That was a deterrent because people were using a lot of the times and one of the things we're going to have to discuss separate from that of the NA, right? It's the fact, the city has been changing their policy. When it comes to many of our members having to submit documentation for their absences. And so many of our members will be going to City MD to get the necessary form in order to get paid, right? And so we saw the numbers spike, and it closest the cost of City MD compared to others was higher, as it was with pro health. But City MD is very high in terms of cost.

Donna: But that all started during Covid, and it was the COVID testing that was actually driving up the price-

Henry Garrido: It actually was before COVID.. It started before COVID. The whole idea of COVID was after the whole idea with testing as required, right? In fact, the city waived the $100 for the testing, the $100 increase started as a savings measure before the COVID pandemic

Donna: It's still an issue, though, because it's hard to get- and I'm sure everybody experiences this. If you are sick today, you're really going to have a hard time getting an appointment with the doctor today, tomorrow. So more of our members use all these urgent cares for those reasons. So when we have a- when there is not sufficient urgent cares in the area, or we have areas where there are not the $50 co pay urgent cares available. I think we just need to have a take a harder look at that and try to see if, the one who's done the one where -

Alan: City health has been incredibly difficult, which I know you know from our meetings. And the one where there are going to be discussions, I believe, is pro health, because pro Health is owned by someone who's ultimately going to the United Healthcare framework, and that's the one that we're putting our attention to right now to see if we can get improvements in there, and basically United Healthcare has said to us, let's get the contract ratified, and then we'll talk to you. No guarantee, then it will change, but that has been raised with the United healthcare.

Questioner: My question is, will there be in-network preferred lists that members can go to to make better formed decisions?

Chris: Yes.. So, you know, you, what Alan mentioned earlier. The short answer of you, a bunch of different questions we got around. Where's the list, right? Where's the list ofthe providers?. We've explained two things. One is, you can ask today if they're in the Emblem Bridge network in the downstate or the United Healthcare Choice Plus Network out of that region. There is a microsite being built that United Healthcare Emblem will not launch, if you will, until we ratify the contract, that will have links to all these networks. So if people want, I don't want to say October 1st, but soon after, they'll be able to go and look and actually look at the doctors that are in the New York City PPO, which is what it's being referred to.

Questioner: The previous slide, in terms of the improved benefits, you had in the list of improved benefits, care management support. You mentioned well, one of the things listed is cardiac rehab. Some of us folks, you know, have to pay particular attention to that. But frankly, [uinteligible] I want to make sure it's, you know, it's really available as opposed to maybe one in two places in here you're lucky or having to run into certain places in Manhattan, you, Upper East Side

Chris: Yes, so, I mean, have we looked specifically at cardiac rehab in Queens? I can't say that we have. But what what this, you know, again, what we've got is commitments from the carriers to hit certain numbers that are not easy to hedge, and what this committee is going to do, starting in January is to make sure they're hitting them. Issues like where are we with urgent care availability, where are we with cardiac rehab, the expectation is, those will be part.

Questioner: I wanted to ask- I thought you said that the senior care optional rider is going to go over the prime therapeutics or the state ESR.

Chris: Emblem healthcare is moving their PBM to prime therapeutics, okay? So any benefit, if you have, I know a few of you, who have emblem healthcare, is your PBM, okay? The administrator behind that will be Prime Therapeutics in 2026. okay? So the senior care plans, through Emblem, the administrator behind it will be Prime Therapeutics, all those things will be. One more question, then I'm gonna finish, and then we can do more questions. It's not long..

Questioner: So, you mentioned that we have a locked in, a premium free for five years. And no payments, just as it was. However, in the contract, it does stay and responsibility. After the effected date, sponsors may modify copayments, deductibles, and impose custom prior authorizations. Now, what do we have in place to prevent them from increasing copayments? Do we have something we can lock it in just as we did with the premium free?

Alan: The answer is just like in the current plan, there can be changes. The answer to you is the city cannot do it unilaterally They have to come and bargain with us and we will be vigilant in protecting our members' interests. They cannot do it themselves.

Chris: So, the other issue that brings up, just to clarify, is the contract that some of you saw is not an insurance contract. It's an administrative services contract. So when we move to an administrative services contract, which is what this is, the contract is about what United Healthcare and Emblem are obligated to do on behalf of the plan, okay? And what the plan looks like is what the city and OLR and MLC tell them to administer.

Okay, so it's a little bit different than when you think about an insurer contract where it includes a schedule [unintelligible]. So all the contracts between Emblem and the City is doing is saying, what are those two parties obligated to each other for? And then there's collective bargaining and everything we do around copays and etcera. Okay, but what this says is the city or the union as contract holder has the right to change those things. It doesn't mean that United Healthcare Emblem will ever change that. They only do it at the direction of the city and unions who will bargain.

Questioner: [unintelligible]

Chris: This is now a self insured plan, which means that you are basically paying somebody to administer the benefit, okay? You are not buying insurance from them. You're paying them to administer the benefit. A few things about that, okay? This plan is essentially run as a self-insured benefit for many years. We moved it to minimum premium, years and years ago, which meant that the only thing that was really insurance was the administrative fees that we paid to the carrier. That's what we paid insurance taxes on, et cetera. As the claims came through, it was the plan's responsibility to pay for them. Moving to an ASA arrangement–a self-insured arrangement doesn't mean because it's a non ERISA plan in New York. It doesn't mean that the state doesn't still watch it, okay? The obligations to the states still exist. The

Department of Financial Services still watches, and has oversight over this plan, what it does do is it gives a little less or a little more leeway in terms of plan design going forward to the plan. It does save a little bit on the taxes that we would pay on insurance, but if you notice, I didn't even put them in the list of things that we're going to save, because a couple of percent on the administrative portion is all we're saving there, it's about $5 million or so. It's not a huge number.

Chris: All right, let me just finish up. We talked about the zero coays. There's a lot of words on this slide. Bottom line takeaway here is nothing's changing to PICA for 2026. Okay. PICA is still gonna be administered by ESI. Important for you all to realize, despite the fact that there is no longer a stabilization fund, that has paid for PICA for the past 25 years. The city will continue to pay for PICA. The PICA will still be in, and will still be over by committee. So we're in the process of finalizing the new contract for ESI, but ESI will remain the direct administrator for the PICA plan in 2026, I say in 2026, because there is a good chance that after that we will review that arrangement again.

We've mentioned before the rider of the diabetic drugs, etc., are moving under emblem to the Prime Therapeutics as the administrator, okay? So there will be some changes to the formulary, like any change to a new PBM, you adopt that PBM's formulary. The matchup here was quite good. It's, you know, a 98% match, and on the rider and it's a 99% match in the diabetics drugs. So there's not going to be a lot that changes. We do look at those drugs that are being switched. They're all well established drugs that also have well established alternatives. This is when there's two choices or more in the market, and you just don't cover one to prefer the other so that you get a better rebate, a better price on one. Importantly, as it exists today, if your member can't take the one that's not on the formula, they can appeal, Okay? And for those of us on the PICA committee, you know those appeals are often pretty effective. So they can appeal as they could today, as they can with any PBM, when they drug is not a formulary, but there is going to be a switch. Some people ask how we're going to know that. The formulary will be up. I think on the microsite we'll confirm that. But there's also, we're getting the current utilization, obviously, Emblem has it from ESI, and they're going to match that up and do aletter campaign, they'll do a few. They'll do one about the switch so everyone knows where to go and what the new PBM is, and for those members affected, there will be a second fourth and usually they do more than one communication about- "your drug is no longer on the formulary, see your doctor talk to them about it, be ready for this when it happens in January."

[Cutting out a back and forth about Walgreens that isn't relevant]

Chris: So prime is a PBM, they still have a very broad network of pharmacies. So they can get their prescription filled anywhere. This is not going to limit them. I do want to put a point on this. Let me look specifically.

Questioner: Yeah, you just mentioned rebates, which have been very, very large, a lot of money. Didn't I see in the contract the other day that the rebate aren't going to union or even the city, aren't they? Are they going to Emblem and United or did I misread?

[Crosstalk]

Henry Garrido: Nothing has changed with ESI. So, what are you talking about the current dispute resolution that we have with ESIs? So just to be clear, there is an ongoing mediation, as it applies to rebates and own price guarantee, some guarantees that we felt ESI was supposed to pass on to us to the city. That has not been resolved. That is still in mediation, but that's not in this conference, that's in the previous. Thank you. All right, Folks, thank you very much-

Questioner: Oh, I have a question broadly about denials. I know in the contract there was some language about the use of an artificial intelligence, and that AI could be used subject to whatever existing laws there are. Given that there isn't really any law, like, regulating the use of AI in healthcare, what kind of oversight processes would the MLC include for the use of AI for denying claims?

Henry Garrido: We haven't had a discussion about AI except that as I said, we are instituting a committee that is going to look at the denials. Not just AI but any denials.

Chris: Yeah, we also Megan, you may have sent this question yesterday. We did ask emblem last night, and they confirmed that they are not using AI around appeals processes. Of course, we're going to have to continue to ask that question. But as of now, there's no use of AI in that process.

Questioner: Yeah, I just had a on the topic of denials. It's great to hear that the MLC is going to be issuing reports around denials to MLC members. Are there any plans to work with the office of Healthcare accountability at the Health Department, on analyzing any of the service data for savings?

Henry Garrido: Well, I know that we established the office of healthcare accountability, by legislation, this administration has not funded the office the way they have to. We are particularly upset about the fact that they failed to post the positions that were in the budget, that were supposed to be 28 people. They said it would be 12, they interviewed 8, they haven't hired anyone yet. So the office in fact exists on paper only. It did put out a report, but by using existing DOHMH employees, and not a newly assigned office and creation. So it's kind of hard to know what the future of that office is going to be. Their role is to put out reports on healthcare costs benchmarks right, and compare them, hospitals and all kinds of other things. But that hasn't happened, right? Except for the one report that was done with the existing staff, it has been no resolution with this administration about continuous funding for the laws.

One thing I will say that apropos is discussion is that I don't think it was mentioned that vaccines will continue to be covered. [uninteligible]

Questioner: you mentioned that there was going to be some obligation for data sharing about our health and welfare fund prescription drug utilization of our members. It was touched on, I think it's a very big issue. I think that I'd like to get more about what's in the contract, what

obligations are. I didn't see it. I tried to look through that document the other day. I didn't see it in there. Did you expand it on that and know what's going on with that?

Alan: What it says is that in order for the carrier to improve the care for our members, the carrier says that they don't have these information early on is going greatly enhance that. They understand that there is sensitivity with this data, that the will has been a document that's in the final stages that will be distributed, which is a confidentiality agreement to make sure that the data– as Chris said can't go to the city, you can't go to other unions, that it's just for this express purpose. We are obliged to have 75 percent of the providers provide this information for that in order to get the full $100 million credit, the five MLC, the exec board members have committed to doing this, which is a large percentage of the membership getting us close to the 75%. The thinking of the MLC executive Board was that even though they understand the sensitivity of this information, that it's really designed to be able to improve the care for the members. So it is these executive board's belief and hope that, you know, all or most will agree to do this.

Questioner: In the event that we vote on this and we vote, yes, we are not obligating ourselves necessarily to give up tha data right? Y

Alan: You are correct.

[Crosstalk]

Questioner: I understand the process, right? But I also, when we say share the data, we're talking about, you know, we're matching up, you know, because we've all done RFP, where we just give them the drugs that we're using, the NDC codes and all that other information, what we removed the personal information, right? So now this process would, if any union decides to participate, of course, would include that partial information, right? Because that's patient information. So it's not only the utilization- it's the personal information and then again, I would have to understand more - how often would we have to share that data? You know what I mean? That we get onto the invoices, so on and so forth.

Henry Garrido: The data as presented is worth one and a half basis points, which is equivalent to about 100 million dollars in savings. So the question that was raised before, is how do we get a billion dollars? This is one of those areas, right? If you don't provide it, you don't get 100 million. So the savings goes in, right? But the purpose of this account is to save money, but to better coordinate care, care management, I think one of the things that I've learned from this process is how inefficient our previous contract tended to be. Part of that inefficient wasn't by design, but because we had silos, right? We have anthem with this stuff here, you had to do with this stuff here. Prescription drug inside here. We had our own data here. If you look at an individual, you can actually do better care management if you had all data as a- And so that I know that's a sensitive subject for folks who may not want to share, but I think the officers in our discussions committed to do this. Right.

[Background conversation]

Questioner: Just a few follow ups. And this is something Jeff Sorkin may know about. Has the has the agreed to cover GLP-1s. Okay, they have not? That is alarming. Because it is recognized as most people know, it is a recognized medical treatment. It is, you know, I don't know what the city is thinking, by not wanting to do this. Less knee replacements, less hip replacements. You know, you'd lose weight, you feel better. It's not, you know, the Kardashians's trying to get into a size zero prom dress, so I don't know what they're thinking by pushing back on this, and just to let everybody know who are not on these PICA calls. When this was raised, I think Claire breaks into a sweat and hives, and she literally hung up on a call once bus when we tried to raise this. So this would be the time to get some kind of commitment before this goes forward. It is so important and there are programs out there that have check ins and weighins and if it's not working, it discontinued. It's just a little my optic to not have GLP1s covered.

Alan: We certainly agree. Just so people have the full picture, GLP-1s are covered to the extensions for diabetes. So ozempic is for diabetes, right? Wegovy, if there's cardiac conditions.. But the city has agreed to return to the table with us about this, once we have the new program. They're not going to agree beforehand. What OLR has said, they said, look, if we are one, you, achieve looking like we're achieving the savings that we're designed, that provides and open door for the argument that you are making, they also said they wanted to see, you further studies, to see whether, in fact, it is a cost effective, it seems to the MLC [uninteligible] that, of course, it would be for the reasons you said, so that is back on the table once we have the new agreement. But it is covered for these other conditions.

Henry Garrido: Yeah, and just so that everybody's clear, we extended the ESI contract. I'm not happy about the ESI condition. With the commitment that we would do an RFP within a year to move forward to what is covered. By the time of the year is over, we'll be talking about GLP 3s. I need GLP, because there is a patent right now, I was reading last night, about that for treatment of things that will be our weight, like for treatments and Crohns disease and a number of other things. So, folks, let me just say this over. This isn't perfect. right? But think about what we were two years ago. With the demise of the stablization, the demand for savings on a recruiingbasis that we were on the agreement. The prospect, real prospect of imposing premiums and co pay increases, not just for co-pays for visits, for co-pays, for drugs, the increasing cost of those drugs, right? The PICA program in spite of a better efforts, continues to go up, right, and they are absolute excuse me. Some of these PBMs are absolutely gangster about what they do in the way they negotiate rebates, the way they keep it, which is one of reasons why we want to create our own in DC 37. We're in the process of doing that, but it's because we seee the practices. I think the fact that the PICA community continues is really important because that was one of the discussions in terms of losing control. As far as what Megan talked about as far as denials and having control of that. This contract, in my opinion, is the best possible scenario we could have happened. And again, it's not perfect, but it does provide the savings without being increased of copays, with an increase network. And for that reason, we think, you know, we're in support of moving forward.

Questioner: Thank you. Just the last thing I have do on my thing just that somebody else said some concerning language and contract that review the other day. I put it in the notes and the emails to Alan and Ellen. It does say the plan sponsor, we're talking about external reviews, independent reviews, if there's denials, when it goes to an IRO. Independent external review for denials such as prior authorization or something to that effect. It does say the plan sponsor vis-a-vis the city does retain full discretion to determine the outcome, which kind of defeats the purpose of having an external review. If the city is just going to say, "No, we don't like that. That decision." And it's exhibit A, section six, if you've got a contract in front of you.

Alan: Thank you. I ask you, that is part of the monthly review.

Questioner: Will we get reporting on that?

Alan: Yes.

Questioner: You did address many of my questions, but I want to clarify two things. There were two committees referenced in the contract. One was the NYCEPPO Review Committee, and then the other was the JLNC Committee. Are they the same? So what's the difference between them and who serves on them?

Chris: One, I don't the two places you're thinking of, but generally speaking, JLMC is the Thursday morning joint labor management committee that you attend and a number of us attend. The NYC PPO review is the new one we're speaking about? That's the monthly review, the plan performance to see that all the commitments that we went through are actually coming. So that new committee will be formed.

Questioner: How does one get on the new committee? Because you reference it's gonna be a very small one

Chris: Yes. Okay. Not my decision.

Questioner: Last question is with our members having the ability to transfer in and out of health plans in late October. They always have the opportunity to review the plan documents. Will we have the opportunity to review these planned documents before the vote? The summary plan document of the actual plan -

Chris: That's a good question. I don't about it but let us ask.

Alan: November 1. The city has agreed to delay the transfer for programs to November 1, so that all the information can be disseminated in October, assuming that there's a ratification September 30th, they have ready all their material going to go out in different phases. Their letters have already been drafted, waiting to go out. And then I think by this October, they're going to have plan information out for people to see.

Questioner: Carmen Charles, DC 37. Once this contract is ratified, can the new mayor, who have been elected two years from now with them not realizing the savings come back to us and say, We need to reopen the contracts. How does that work? Just thinking out..

Alan: The answer is they can always come back. The response is, we're on no obligations change. And this, gets into overall bargaining.

[Close out]