Appellate Division, First Department, Docket No. 2022-01006
New York County Clerk's Index No. 158815/2021

Court of Appeals
State of New York

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, and PHYLLIS LIPMAN,

Petitioners-Respondents,

against

RENEE CAMPION, CITY OF NY OFFICE OF LABOR RELATIONS, and THE CITY OF NEW YORK,

Defendants-Appellants.

MOTION FOR LEAVE TO APPEAL

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants
100 Church Street
New York, New York 10007
Tel: 212-356-2275 or -2500
Fax: 212-356-1148
jschoepp@law.nyc.gov

RICHARD DEARING
DEVIN SLACK
JONATHAN SCHOEPP-WONG
CHLOE K. MOON
of Counsel

January 6, 2023

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NOTICE OF MOTION FOR LEAVE TO APPEAL

PLEASE TAKE NOTICE that upon the annexed memorandum and affirmation, defendants-appellants will move this Court, located at 20 Eagle Street, Albany, New York 12207, on January 23, 2023, at 10:00 a.m., or as soon thereafter as counsel can be heard, for leave to appeal from the order of the Appellate Division, First Department, entered on November 22, 2022, and for such other relief as the Court may deem just and proper.

Dated: New York, New York
January 6, 2023

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants

By: _____
JONATHAN SCHOEPP-WONG
Assistant Corporation Counsel

100 Church Street
New York, New York 10007
212-356-2275
jschoepp@law.nyc.gov

To: Jacob S. Gardener
WALDEN MACHT & HARAN LLP
250 Vesey Street, 27th Floor
New York, NY 10281
212-335-2965

Steve Cohen
POLLOCK COHEN LLP
111 Broadway, Suite 1804
New York, NY 10006
Attorneys for Respondents

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MEMORANDUM IN SUPPORT OF MOTION FOR LEAVE TO APPEAL

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants
100 Church Street
New York, New York 10007
Tel: 212-356-2275 or -2500
Fax: 212-356-1148
jschoepp@law.nyc.gov

RICHARD DEARING
DEVIN SLACK
JONATHAN SCHOEPP-WONG
CHLOE K. MOON
of Counsel

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PRELIMINARY STATEMENT

This case presents critical questions about the scope of the City of New York's obligation to provide premium-free healthcare to its retired workforce under Administrative Code § 12-126. For years, the City has worked with municipal unions to rein in ballooning healthcare costs for both employees and retirees—the costs for retirees alone have tripled over the past two decades, approaching $1 billion annually. To address this fiscal challenge, the City sought to offer a new, union-backed, and premium-free Medicare Advantage insurance plan to eligible retirees, while giving them the option to stay in their old plan and pay the premiums. By taking advantage of untapped federal subsidies, this arrangement was expected to save City taxpayers $600 million every year, while still providing retirees with a premium-free plan offering equivalent or better healthcare coverage and with the option to select other plans at their own expense.

But the Appellate Division, First Department, concluded that § 12-126 imposes a Hobson's choice: the City must either reject over half a billion dollars in necessary annual savings, or make a new

Medicare Advantage plan the *only* option for Medicare-eligible retirees and cancel the rest. Considering the fiscal environment, that is no choice at all. Indeed, as a direct result of the Appellate Division's ruling, an arbitrator designated by the City and municipal unions to resolve disputes in this area has ordered the City to implement a Medicare Advantage plan and eliminate all other plans for Medicare-eligible retirees that impose any costs on the City, absent a legislative intervention that is anything but certain.

The very reason petitioners brought this lawsuit was to maintain their preferred healthcare plan. But the Appellate Division's ruling pushes toward a world where Medicare-eligible retirees will no longer have the option of choosing that plan and roughly a dozen others. Rather than preserve the retirees' ability to choose among plans, with one premium-free option, the Appellate Division's ruling instead threatens to remove any choice whatsoever. This Court should grant leave to appeal to ensure that this outcome never comes to be, or at least does not last long.

To get to its result satisfying no one, the Appellate Division had to stray far from Administrative Code § 12-126's text and history. Section 12-126's command is both significant and defined: by its terms, the City must "pay the entire cost of health insurance coverage" for employees, retirees, and their dependents—with the City's monetary obligation capped at a level tied to the relevant category of insurance provided. And the City would fully satisfy this command as to the only category at issue here, Medicare-eligible retirees, by making available a robust, premium-free Medicare Advantage plan providing hospital, surgical, and medical benefits. Yet the Appellate Division required the City to also pay for *any* plan that the City may offer—even optional "step-up" plans.

At the same time, the Appellate Division refused to state *how much* its interpretation of § 12-126 requires the City to pay, leaving in place Supreme Court's permanent injunction without addressing petitioners' claim that the law also requires the City to pay over four times as much as the actual cost of their preferred plan. Nothing in § 12-126 requires such a nonsensical result.

OVERVIEW OF THE CASE

A. The backdrop of Administrative Code § 12-126

Long before Administrative Code § 12-126 existed, the City provided high-quality healthcare coverage to its public servants. In the 1940s, the City offered coverage through the Health Insurance Plan of Greater New York (HIP), then a nonprofit, finding it to be "comprehensive and complete" (Record on Appeal ("R") 1357–76). Blue Cross supplied hospitalization insurance (R1350, R1365–66).

In the 1960s, the City agreed to "provide a choice of health insurance"—comprising three enumerated plans—to municipal employees and retirees (R1341–48, 1350–51). In a separate provision, the City agreed to pay for "such choice," though with the cost "not to exceed 100% of the full cost of H.I.P.-Blue Cross (21-day Plan) on a category basis" (R1343–45). In recognition of differences in the healthcare needs of employees and those retirees generally, the City specifically allowed providers to charge different premiums for those two categories (R1344–45).

Medicare's enactment in 1965—and the federal healthcare benefits it provided to those 65 and older—was a sea change. It

prompted the City to reexamine its healthcare offerings both to "further the health and welfare of the City's employees and retirees, and protect the interests of the City" (R1347). As part of that reexamination, when Medicare went into effect, the City began offering Medicare-eligible individuals so-called "Medigap" plans, providing secondary coverage supplementing Medicare (R1339).

In 1967, the City Council considered codifying an obligation on the part of the City to provide healthcare coverage to its active and retired workforce and their dependents. Its first attempt—which would have required the City to "pay for the entire cost of *any* basic health insurance plan" (R1324 (emphasis added))—proved too expansive. The Mayor vetoed the bill, objecting to the "open-ended obligation" to pay "the entire cost of any basic health insurance plan" (R1326).

Local Law 120 of 1967, codified at Administrative Code § 12-126, jettisoned that open-ended obligation in favor of requiring the City to cover "the entire cost of Health Insurance Coverage for City employees, City retirees, and their dependents" (R1320–21, 1331–32). "Health Insurance Coverage" was defined in the singular

as: "[a] program of hospital-surgical-medical benefits" (R1320, 1332).

The law also established a category-based monetary cap, requiring the City to pay to no more than "one hundred per cent of the full cost of H.I.P.-Blue Cross (21-day plan) on a category basis" (R1321, 1335). At the time, the HIP product referenced in the law already differed significantly for Medicare-eligible individuals and everyone else—for the former, coverage was only a secondary "Medigap" plan that supplemented Medicare (R1338–39).

The law also recognized that Medicare-eligible individuals were different in other ways. For these individuals whose insurance was "predicated on the insured's enrollment in [Medicare]," the City was required to cover Medicare Part B premiums, on top of the supplemental "Medigap" coverage (R1320–21).[1]

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[1] Medicare Part B covers services from doctors, outpatient care, durable medical equipment, and many preventive services. *See Part B Costs*, U.S. Ctrs. for Medicare and Medicaid Servs., https://perma.cc/8XRL-GA7G. By contrast, Medicare Part A provides hospital insurance and is generally premium-free. *See Part A Costs*, U.S. Ctrs. for Medicare and Medicaid Servs., https://perma.cc/ZMX5-AXF7.

The law also omitted language that would have limited the City's flexibility in selecting a healthcare plan. Unlike the City's then-existing agreements with municipal unions, the law did not require the City to pay for a "choice of health and hospital insurance" (R1350–51, 1342–45). And the Council considered and rejected a proposal that would have prohibited the City from reducing benefits in the future (R1320–21, 1331–35).

Local Law 28 of 1984 amended Administrative Code § 12-126 to update the category-based monetary cap, as the referenced HIP product had been discontinued (R1141–43, 1408–11, 1414). As amended, § 12-126 now requires the City to "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" (R1134).[2] Like its discontinued predecessor, the referenced HIP/HMO recognized the fundamental difference between Medicare-eligible retirees and everyone else.

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[2] An HMO, or Health Maintenance Organization, is a managed care insurance plan through which a primary care physician manages each member's health care needs and typically requires the use of network doctors and facilities (R111). By contrast, a PPO, or participating provider organization, typically offers the freedom to use either a network or out-of-network provider (R111).

For the former, Medicare provided the "first level of benefits," with the HMO covering only "gaps in Medicare coverage" (R1414).

Corresponding HIP HMO plans are available today through HIP's successor, EmblemHealth. For Medicare-eligible retirees, the current HMO is HIP VIP Medicare ("HIP VIP HMO"), which has relatively low monthly premiums ($182 in 2021) because it is only a secondary "Medigap" plan (R148, 157, 1282–83, 1282–83, 1293–94). For everyone else, the relevant HMO is HIP HMO Preferred, with monthly premiums roughly four times higher ($776 in 2021) because it serves as "primary" insurance (R106, 133, 1282–83).

B. The City's past agreements with unions to exceed its obligations under § 12-126, and the pressing need to find healthcare savings

Administrative Code § 12-126 codifies a minimum obligation that the City must meet, using HIP's HMO products to create a category-based monetary cap on that minimum obligation (R1134). But the City has often agreed through collective bargaining to exceed its minimum obligation under the Administrative Code.

For example, in 2021, as it had in the past, the City agreed with the Municipal Labor Committee (MLC)—an association of

municipal unions—to make GHI Senior Care a premium-free option for Medicare-eligible retirees (R1282–83, 1294; NYSCEF No. 61 at 3–5).[3] As a secondary "Medigap" plan, Senior Care's monthly premiums are far lower than would be charged for plans providing comparable benefits to those who are not Medicare-eligible: $192 in 2021, about $10 more than HIP VIP HMO (R102–03, 111, 148, 151, 1282–83, 1293–94; NYSCEF No. 77 at 4).

Over time, rising healthcare costs pushed the City and the MLC to examine "savings and efficiencies in the method of health care delivery," including taking advantage of substantial Medicare subsidies, to preserve the "longer term sustainability of health care for workers and their families" (NYSCEF No. 61 at 6–8). Skyrocketing healthcare costs are a nationwide phenomenon; even before the pandemic, national healthcare spending was expected to easily outpace GDP and exceed $6 trillion by 2028.[4]

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[3] Unless otherwise noted, NYSCEF references are to the Supreme Court docket (Index No. 158815/2021).

[4] *NHE Fact Sheet*, U.S. Ctrs. for Medicare & Medicaid Servs., https://perma.cc/UD9H-QWPU (last visited Mar. 20, 2022).

Medicare Part B premiums have also more than tripled in the past 20 years, with a nearly 15% increase in the last year alone.[5] Overall, the City's Part B reimbursement costs have risen sevenfold over a similar 20-year period (NYSCEF No. 118 at 16). Despite these trends, the City and the MLC agreed that any adjustments to the City's healthcare offerings should "maintain and improve upon existing retiree benefits while at the same time reducing cost" (NYSCEF No. 61 at 8; *see* R884, 908–09; NYSCEF No. 118 at 17).

At first, the City and MLC focused on reducing expenses for active employees (R909; NYSCEF No. 61 at 7–8). For many years, limited changes were made to retiree plans, although costs were rapidly increasing there (R909). By 2020, however, the City and the MLC concluded that providing a Medicare Advantage plan to Medicare-eligible retirees would provide "equivalent or better benefits" as compared to Senior Care (NYSCEF No. 118 at 17; *see* R884–90, 908–09), while still realizing $600 million in annual savings simply by taking full advantage of untapped Medicare

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[5] Tricia Neuman et al., *Monthly Part B Premiums and Annual Percentage Increases*, Kaiser Family Foundation (Jan. 12, 2022), https://perma.cc/3QYA-NG3J.

subsidies (R907–09; NYSCEF No. 61 at 8; NYSCEF No. 118 at 15–16).

And so, the City and MLC agreed to make a new Medicare Advantage plan the premium-free offering for Medicare-eligible retirees, replacing Senior Care (NYSCEF No. 61 at 3–11). Seeking to gain access to increased federal funds and superior efficiencies while also maintaining benefits, the City and the MLC leveraged their joint bargaining power to customize a plan to provide "the same comprehensive coverage [as Senior Care] in the context of a Medicare Advantage structure and add[] certain additional benefits not available under Senior Care" (R907–09).

C. This litigation, the Appellate Division's ruling, and the immediate shockwaves

Petitioners are a handful of retirees and a corporation created for the purpose of this litigation purporting to have a "membership" comprising a small fraction of retirees (R26–28, 32–34, 61). After the City announced its plan to roll out a new Medicare Advantage plan, petitioners brought this article 78 proceeding, arguing, among other things, that Administrative Code § 12-126 requires the City

to pay $776 dollars per month per person for the plan of each retiree's choosing. This amount corresponds with the premiums for HIP HMO Preferred, a primary insurance plan that is available only to persons ineligible for Medicare (R28, 34, 69; NYSCEF No. 189 at 7).

The case proceeded on a rather irregular procedural path. The City moved to dismiss and, over the course of several months, the parties and various amici made a number of submissions regarding the plan's implementation. Before the City's motion was decided and any answer had been filed, however, petitioners moved for summary judgment, prompting an opposition from the City, amicus briefs supporting the City from both the MLC and the insurance plan's proposed providers, petitioners' reply to both the City's and amici's arguments, and post-hearing submissions (NYSCEF Nos. 201, 205, 206, 208, 212–13).

The City argued that § 12-126 only requires it to provide one premium-free option and caps its financial obligation at "the full cost of H.I.P.-H.M.O. on a category basis" (NYSCEF No. 79 at 6). That duty would be satisfied through the new Medicare Advantage

plan, which would be available to Medicare-eligible retirees premium-free.[6] Nothing in § 12-126, the City argued, requires it to pay for other plans. And the City advocated in a post-argument submission—responded to by petitioners—that even if the law required payment for other plans, the cap "on a category basis" would not equal the premiums for the HIP HMO available to individuals who are ineligible for Medicare, but rather the substantially lower premiums for the HIP HMO that is actually offered to Medicare-eligible retirees: HIP VIP HMO (R1970–71; NYSCEF No. 205 at 15).

Supreme Court, New York County (Frank, J.), denied the City's motion and granted the petition in part (R7–10). Although the court held the City could offer a Medicare Advantage plan, the court permanently enjoined the City "from passing along any costs of the New York City retirees' current plan to the retiree or to any of their dependents, except where such plan rises above the H.I.P.-

[6] The MLC, for its part, agreed (NYSCEF No. 205).

H.M.O. threshold, as provided by New York City Administrative Code Section 12-126" (R10).

According to the court, § 12-126 means that "so long as the [City] is giving retirees the option of staying in their current program, they may not do so by charging them the $191 the respondent intends to charge" (R8). As the court made clear, its ruling did not require the City to "give retirees an option of plans," but if the City did choose to do so, the court's "understanding" was that "the cost of the retirees' current health insurance plan" did not surpass § 12-126's monetary cap (R9). Thus, the City could not "pass any cost of the prior plan to the retirees" (R9).

The court also rejected the City's argument that the premium cost of Senior Care exceeded § 12-126's cap. While petitioners argued that the City's argument on that point came too late to be considered, Supreme Court addressed the point on the merits, reasoning that its understanding of the City's historical practice supported the conclusion that the cost of Senior Care fell below the statutory cap (R9).

The City perfected an appeal at the earliest opportunity (R3). But after petitioners successfully delayed the appeal for months, the provider of the original Medicare Advantage plan at issue backed out (1st Dep't 2022-01006 NYSCEF No. 33). Through nothing but procedural delay, petitioners had achieved one of their goals and cost the City and its taxpayers hundreds of millions of dollars in lost savings.

The appeal proceeded because Supreme Court's permanent injunction remained in place, continuing to prevent the City from implementing a new Medicare Advantage plan with a different provider while offering retirees a choice of plans (*id.*). The City was then—and remains—in negotiations with Aetna to offer another Medicare Advantage plan, but Supreme Court's permanent injunction is a roadblock.

The Appellate Division, First Department, affirmed Supreme Court's judgment, including the permanent injunction. Describing the question of whether § 12-126 requires the City pay for more than one plan as an issue of "pure statutory interpretation," the Appellate Division adopted Supreme Court's conclusion that

"Administrative Code § 12-126(b)(1) requires respondents to pay the entire cost, up to the statutory cap, of any health insurance plan a retiree selects" (Ex. A at 2). But like Supreme Court, the Appellate Division limited this obligation to the plans actually "offered to retirees" (*id.*), similarly leaving the door open for the City to cancel all retiree plans except for its new Medicare Advantage plan.

On the question of whether the requirement to pay for Medicare-eligible enrollees was tied to the enormously higher rate applicable to those ineligible for Medicare, the court demurred (*id.*). According to the court, the nature of § 12-126's statutory cap was "raised for the first time on appeal" and "further evidence" was necessary to determine what the statute's language meant (*id.*).

The consequences were swift and profound. Within weeks of the ruling, an arbitrator overseeing negotiations between the City and municipal unions concerning the City's healthcare offerings directed the parties to "reach an agreement with Aetna" on a new Medicare Advantage plan (Ex. B at 29). To comply with Supreme Court's injunction as affirmed by the Appellate Division, however, the arbitrator declared that "Senior Care shall no longer be an

offering" and that any other offerings would have to be "at no cost to the City" (*id.* at 30). Unless the City Council amends § 12-126, Medicare-eligible retirees will have no choice but to enroll in the new Medicare Advantage plan, or else find healthcare coverage from avenues other than the City.

On January 3, 2023, a bill was introduced in the City Council to amend § 12-126 and clarify that it permits the City to offer both a free health insurance plan as well as Senior Care and other plans if enrollees were willing to pay for them. In a joint statement, the Council Speaker and the bill's sponsor emphasized that the amendment's goal was to "preserve retirees' choice of health insurance rather than have them automatically enrolled in Medicare Advantage as the sole plan."[7] Nevertheless, petitioners have sought to derail this amendment as well, even though the alternative is losing Senior Care entirely, and the bill's passage is far from assured.

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[7] Press Release, Speaker Adrienne Adams & Councilmember Carmen De La Rosa (Jan. 3, 2023), *available at* https://perma.cc/5FRZ-NLD8.

TIMELINESS AND JURISDICTION

This motion is timely under CPLR 5513(b) because it was made on January 6, 2023—within 30 days of the December 7, 2022, service of notice of entry of the Appellate Division's order (*see* Ex. A). This Court has jurisdiction to grant leave to appeal because the order appealed from finally determined the proceeding and is not appealable as of right. CPLR 5602(a)(1)(i). The Appellate Division affirmed the lower court's final judgment that resolved all substantive issues and granted a permanent injunction (R10).

REASONS TO GRANT LEAVE

The Appellate Division's deeply flawed and incomplete interpretation of § 12-126 raises novel issues of tremendous public importance that warrant this Court's review. The courts below imposed a mandate to pay for any healthcare plan that the City offers to retirees, thereby hamstringing its ability to respond to the mounting fiscal challenges arising from providing free healthcare to hundreds of thousands. As a result of the Appellate Division's ruling, absent an uncertain legislative intervention, the City will soon be required to cancel all Medicare-eligible retiree healthcare

offerings that impose any costs on the City, imperiling the very choice that petitioners ostensibly brought this litigation to protect.

This case is and will be the Court's only opportunity to address whether § 12-126 requires this result. The permanent injunction in this case will almost certainly prevent the City from reaching another agreement with any insurance company to provide free healthcare to the City's retirees while giving them the ability to choose a different plan. The evaporation of the previous Medicare Advantage plan proves this reality: even before the Appellate Division ruled, the provider for that plan pulled out because of the burdens of Supreme Court's injunction. And now, absent this Court's intervention, the City may never again be in a position to offer a suite of health insurance options to retirees.

A. The impact of the Appellate Division's decision is substantial and wide-ranging.

The Appellate Division's understanding of the law makes little sense. The court accepted Supreme Court's conclusion that nothing in § 12-126 requires the City to provide more than one insurance plan at all. That conclusion is clear from the plain

language of the law, which omits any reference to a "choice" of plans—let alone any description of what the choice must include—and in doing so departs sharply from previous resolutions of the City's Board of Estimate that were framed precisely in those ways. Given that the law's text was otherwise patterned on language from those Board of Estimate's resolutions, the Council's rejection of the provisions about "choice" speaks volumes. Both courts correctly understood that.

But the courts failed to follow that insight to its logical conclusion. It is hard to see why the City Council would create a regime that does not require any alternative plans to be offered, but compels the City to pay for them if they are offered, subject only to the law's monetary cap. There is no good reason to eliminate the option of providing alternatives but requiring those who elect them to pay for them.

The consequences of the Appellate Division's ruling immediately became clear. The ruling ensured that the City would be unable to achieve $600 million in yearly healthcare savings by offering a free Medicare Advantage plan to retirees while requiring

that they contribute premiums only if they were to choose a different plan. Responding to the ruling, the arbitrator selected to resolve healthcare disputes between the City and its municipal unions directed the City and MLC to move forward with a Medicare Advantage plan and cancel all other plans requiring a City contribution—including petitioners' preference, Senior Care. And so, absent a last-minute legislative intervention, the Appellate Division's ruling will now result in the City being forced to limit retirees' choices to no obvious end.

While the City firmly believes that any plan it would have provided would offer superior insurance, some retirees, including petitioners, object to any Medicare Advantage coverage whatsoever. Yet the Appellate Division's ruling threatens to force all 200,000 retirees in Senior Care into a Medicare Advantage plan that petitioners do not want. And all of these Medicare-eligible retirees will lose their existing healthcare plan, even if they were willing to pay for it.

B. The Appellate Division's interpretation conflicts with § 12-126's plain meaning.

A proper reading of § 12-126 does not require this nonsensical result. As this Court has repeatedly concluded, in matters of statutory construction, "[t]he primary consideration … is to ascertain and give effect to the intention of the Legislature." *People v. Santi*, 3 N.Y.3d 234, 243 (2004). The inquiry begins with the statutory text—"the clearest indicator of legislative intent"—and also considers the law's "spirit and purpose," as illuminated by its context and legislative history. *Matter of Albany Law School v. N.Y.S. Office of Mental Retardation & Dev. Disabilities*, 19 N.Y.3d 106, 120 (2012).

Here, the Appellate Division waved away the statute's language and legislative history without explanation, yet all of these sources confirm that the City's interpretation is correct. The law's text states in relevant part that "[t]he city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents." And the City would plainly pay the entire cost of coverage for Medicare-eligible retirees through a premium-

free Medicare Advantage plan.[8] That conclusion is unchanged even if the City also gives Medicare-eligible retirees the ability to decline that plan and opt-in to others, for which they must then pay.

Moreover, several factors decisively undercut any other reading. First, the law defines "health insurance coverage" in singular terms, as "[a] program of hospital-surgical-medical benefits." When that definitional language is substituted into the operative sentence, it becomes "[t]he city will pay the entire cost of [a program of hospital-surgical-medical benefits] for city employees, city retirees, and their dependents." Providing a premium-free Medicare Advantage plan meets that requirement, full stop.

Second, the law's definition of "health insurance coverage" gains added significance when one considers the law's enactment history. The City Council rejected a prior version of the law that would have required the City to pay for "any basic health insurance plan," after the Mayor vetoed that bill. The Council thus knew how to draft language that would require the City to pay for any

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[8] "Cost," in this context, refers to premiums. *See N.Y. 10-13 Ass'n v. City of N.Y.*, 1999 U.S. Dist. LEXIS 3733, *35–38 (S.D.N.Y. Mar. 29, 1999). Petitioners have never argued otherwise in this litigation.

available plan that met certain criteria, yet specifically declined to adopt such language in § 12-126.[9] The Appellate Division's approach thus "read[s] into [the] statute a provision which the Legislature did not see fit to enact." *Chem. Specialties Mfrs. Ass'n v. Jorling*, 85 N.Y.2d 382, 394 (1995) (internal quotation marks omitted).

The City Council also declined other opportunities to incorporate language that would have codified an obligation to pay for retirees' choice among multiple plans. Two years before the adoption of § 12-126, the City had agreed with municipal unions to cover "total payment *for choice* of health and hospital insurance" among multiple plans (R1342 (emphasis added)). The resolution adopting this agreement also included a separate provision guaranteeing that a choice would be provided and identifying the

[9] Petitioners have repeatedly sought to elevate a City Council committee report stating that the City would "pay for the entire cost of any health insurance plan" as a definitive statement on the enacted law's effect (R1327). But practically identical language was explicitly rebuffed in the final bill, and the report merely repeated verbatim its description of the more expansive version without accounting for *any* of the substantial changes to the bill following the Mayor's veto, calling the report's reliability into serious question.

specific plans among which retirees could choose (R1342, 1344). But § 12-126 pointedly did *not* include such language.

Petitioners throughout this litigation have instead hung their hat on § 12-126's definition of "health insurance coverage" as a program of insurance benefits to be provided by "contracts" with "companies"—plural terms that they say requires the City to pay for multiple plans. § 12-126(a)(iv). But it would be odd for the City Council to eschew readily available language that would have directly guaranteed payment for multiple plans in order to introduce such a meaningful concept obliquely, via nuances gleaned from ancillary terms in a definition. What's more, the nuances petitioners perceive are illusory, as it is common for a single insurance plan to comprise multiple "contracts" and "companies." Senior Care, petitioners' own preferred plan, does just that. And § 12-126's original benchmark plan—indeed *all* of the City's plan offerings as of the law's enactment—also did precisely that.

If the City Council had intended to mandate a choice of free plans, it had the means to do so. The driving force behind this litigation was petitioners' claim that they were entitled to keep the

plan of their choice on a premium-free basis because it was free to them in the past. But a version of the bill immediately preceding § 12-126's passage included language that would have barred the City from reducing the healthcare benefits it was then offering—at that time, a subsidized choice of plans (R1320, 1332, 1335). That text was stricken from the final bill. A fortiori the City Council did not intend to freeze particular plan arrangements in place.

Instead, the Council intended § 12-126 to give the City flexibility to structure healthcare arrangements as policy and budgetary needs may dictate, so long as a premium-free plan is provided. And let there be no mistake: the local law's guarantee that city workers—and their dependents—will not have to pay any premium amount for healthcare insurance—not just during the employees' working life but through their retirement as well—is one that few workers across America enjoy. It makes sense that the Council would have preserved the City's flexibility to deliver on that rare promise in a manner that both fully utilizes available federal subsidies *and* preserves choice for enrolled employees who opt to pay for their own coverage at the City's group rate.

C. The Appellate Division's incomplete decision invites confusion.

While the above points alone justify leave, the Appellate Division compounded its error by reaching the first half of the sentence describing the City's obligation under § 12-126(b)(1) but not addressing the second half of that sentence. According to the court, although the baseline obligation to pay "the entire cost of health insurance coverage" was discernible through traditional interpretive methods, the statute's obligation to pay up to "the full cost of H.I.P.-H.M.O. on a category basis" was raised too late and required "further evidence" to resolve (Ex. A at 2). But not only was this issue preserved, it was also a pure question of law that the court should have decided regardless. By not doing so, the Appellate Division injected significant uncertainty into its own mandate that this Court should address.

To be clear, the Appellate Division was simply wrong that this issue was not previously raised. *See, e.g.*, *U.S. Bank N.A. v. DLJ Mortg. Capital, Inc.*, 33 N.Y.3d 84, 89 (2019) (argument preserved if party asked court to resolve it); *Geraci v. Probst*, 15 N.Y.3d 336, 342 (2010) (same). The City and an amicus curiae both argued

below that the statutory cap for Medicare-eligible retirees was the HIP HMO plan available to them, petitioners responded, and Supreme Court weighed in on the question (R7–9, 1970–71; NYSCEF No. 205 at 15–16; NYSCEF Nos. 208, 213). In particular, petitioners argued to Supreme Court that the issue should be deemed unpreserved, yet Supreme Court opted to resolve the point solely on its merits. Under those circumstances, the First Department was flatly mistaken in holding that the argument was raised for the "first time on appeal" (Ex. A at 2).

Even setting these points aside, this Court has long held that "question[s] of statutory interpretation" may be raised for the first time on appeal, even in this Court. *Richardson v. Fiedler Roofing, Inc.*, 67 N.Y.2d 246, 250 (1986). It is evident from the statute's text, requiring no further evidence, that the cap for Medicare-eligible retirees, "on a category basis," refers to the HIP HMO plan that is available to Medicare-eligible retirees and not to a HIP HMO plan that is unavailable to such retirees, that bears no actuarial relationship to the costs of covering those retirees, and that is thus

several times more expensive than any comparable, actuarially relevant plan would be.

While the Appellate Division also questioned the City's assertion that the statutory cap based on HIP VIP HMO would be only $7.50 per month (Ex. A at 2), that factual assertion bears no relevance to the question of what the local law's text means. The premiums for HIP VIP HMO have been lower than Senior Care for many years. If petitioners wish to challenge the publicly announced and State-approved price for HIP VIP HMO, that dispute is separate from determining whether § 12-126's statutory language establishing the cap as "the full cost of H.I.P.-H.M.O. on a category basis" refers to the HIP HMO plan that is available to Medicare-eligible individuals or the HIP HMO plan that is not. The First Department failed to recognize that critical distinction.

And the answer to the statutory question is clear. As the statute's text dictates, the City must "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*." § 12-126(b)(1) (emphasis added).

This means that the cap varies by the category of insurance provided, thus ensuring that the comparison is an apples-to-apples one. The only HIP HMO available to Medicare-eligible retirees "on a category basis" is HIP VIP HMO, and § 12-126 requires payment only up to that plan's threshold.

This understanding is further embodied in the law's express references to Medicare enrollees. The law includes a specific provision requiring the City to pay Medicare Part B premiums when an individual's coverage is "predicated" on Medicare. § 12-126(b)(1). Thus, the City Council was well aware that some city-offered plans would provide coverage supplemental to Medicare, and specified that they should receive different treatment from plans for those ineligible for Medicare. Appropriately adjusting § 12-126's requirements based on Medicare eligibility also makes eminent policy sense: after all, City taxpayers fund Medicare too, and the City Council would not have enacted a law requiring them to pay for both Medicare subsidies as well as retiree healthcare that ignored those benefits.

* * *

The Appellate Division's decision affirming Supreme Court's injunction scrambles the City's ability to provide quality and fiscally sound health insurance to retirees. The result is that hundreds of thousands of retirees are on the threshold of no longer having the option of continuing their current plan and paying the premiums, and instead face the prospect of accepting a different premium-free offering some would otherwise reject. The Court should intervene in this matter to allow the City to address its fiscal challenges while also maintaining the retiree choice that it has tried to protect throughout this litigation, so that retirees may have the option to remain in their current plan subject to premium contributions, or to select a free Medicare Advantage plan providing equivalent or better coverage.

CONCLUSION

This Court should grant leave to appeal.

Dated: New York, New York
January 6, 2023

Respectfully submitted,

HON. SYLVIA O. HINDS-RADIX
Corporation Counsel
of the City of New York
Attorney for Appellants

By: _____
JONATHAN SCHOEPP-WONG
Assistant Corporation Counsel

100 Church Street
New York, New York 10007
212-356-2275
jschoepp@law.nyc.gov

RICHARD DEARING
DEVIN SLACK
JONATHAN SCHOEPP-WONG
CHLOE K. MOON

of Counsel

Appellate Division, First Department, Docket No. 2022-01006
New York County Clerk's Index No. 158815/2021

Court of Appeals
State of New York

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, and PHYLLIS LIPMAN,

Petitioners-Respondents,

against

RENEE CAMPION, CITY OF NY OFFICE OF LABOR RELATIONS, and THE CITY OF NEW YORK,

Defendants-Appellants.

AFFIRMATION IN SUPPORT OF MOTION FOR LEAVE TO APPEAL

JONATHAN SCHOEPP-WONG, an attorney admitted to practice in the courts of this state, affirms under the penalties of perjury as follows.

1. I am an Assistant Corporation Counsel in the Office of the Corporation Counsel of the City of New York, which represents appellants in this article 78 proceeding brought by the NYC Organization of Public Service Retirees, Inc., and six individual petitioners. I make this affirmation based on my personal

knowledge and my review of our office's records, which I believe to be accurate.

2. Petitioners commenced this article 78 proceeding in Supreme Court, New York County, to challenge the City's implementation of a premium-free Medicare Advantage health insurance plan for eligible retirees.

3. By decision and order entered March 3, 2022, Supreme Court resolved the article 78 petition and granted a permanent injunction barring the City from "passing along any costs of the New York City retirees' current plan to the retiree or to any of their dependents, except where such plan rises above the H.I.P.-H.M.O. threshold, as provided by New York City Administrative Code Section 12-126."

4. On November 22, 2022, the Appellate Division, First Department, affirmed Supreme Court's order and the permanent injunction. Petitioners served notice of entry of the Appellate Division's decision and order on December 7, 2022, by filing notice on NYSCEF. A true and correct copy of the notice of entry and the Appellate Division's order is attached as **Exhibit A**.

5. On December 15, 2022, the arbitrator selected to resolve disputes regarding the City's health insurance offerings issued an opinion and award directing the City and the Municipal Labor Committee to "reach agreement" with Aetna on a new Medicare Advantage plan for eligible retirees and to cease offering Senior Care, petitioners' current insurance plan. Any other offerings would also have to be "at no cost to the City." A true and correct copy of the arbitrator's opinion and award is attached as **Exhibit B**.

6. For the reasons set forth in the accompanying memorandum of law, appellants now respectfully seek leave to appeal from this Court.

7. The motion for leave to appeal is timely pursuant to CPLR 5513(b) because it is made within 30 days of petitioners' service of notice of entry on December 7, 2022.

Dated: New York, New York
January 6, 2023

_____

JONATHAN SCHOEPP-WONG
Assistant Corporation Counsel

100 Church Street
New York, New York 10007
212-356-2275
jschoepp@law.nyc.gov

EXHIBIT A

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

In the Matter of the Application of

LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, PHYLLIS LIPMAN, on behalf of themselves and others similarly situated, and the NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., on behalf of former New York City public service employees who are now Medicare-eligible Retirees,

Petitioner,

For Judgment Pursuant to CPLR Article 78

- against -

RENEE CAMPION, as Commissioner of the City of New York Office of Labor Relations, CITY OF NEW YORK OFFICE OF LABOR RELATIONS, the CITY OF NEW YORK,

Respondents.

Index No.: 158815/2021

NOTICE OF ENTRY OF JUDGMENT

PLEASE TAKE NOTICE that the attached is a true and correct copy of the Decision and Order of the Supreme Court, Appellate Division, First Department, entered by the Clerk of the Court on November 22, 2022, and filed electronically on NYSECF the same day.

Dated: December 7, 2022
New York, NY

WALDEN MACHT & HARAN LLP

By:/s/ *Jacob S. Gardener*
Jacob S. Gardener
250 Vesey St., 27th Floor
New York, NY 10281
(212) 335-2965
jgardener@wmhlaw.com

POLLOCK COHEN LLP
Steve Cohen
111 Broadway, Suite 1804
New York, NY 10006
(917) 364-4197
SCohen@PollockCohen.com

Attorneys for Plaintiff

To: All Counsel of Record (**VIA NYSCEF**)

Supreme Court of the State of New York
Appellate Division, First Judicial Department

Renwick, J.P., Manzanet-Daniels, Oing, Moulton, González, JJ.

16722 In the Matter of NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., et al., Petitioners-Respondents-Appellants,

-against-

RENEE CAMPION et al., Defendants-Appellants-Respondents.

Index No. 158815/21
Case No. 2022-01006

Sylvia O. Hinds-Radix, Corporation Counsel, New York (Richard Dearing of counsel), for appellants-respondents.

Walden Macht & Haran LLP, New York (Jacob S. Gardener of counsel), for respondents-appellants.

Judgment (denominated an order), Supreme Court, New York County (Lyle E. Frank, J.), entered on or about March 3, 2022, which, to the extent appealed from, granted the petition to the extent of allowing New York City retirees to have the option of opting out of the Medicare Advantage Plan, enjoining respondents from passing along any costs of the retirees' current plan to the retirees or their dependents except where such plan rises above the H.I.P-H.M.O threshold provided by Administrative Code of City of NY § 12-126, and requiring respondents to ensure that all retirees and their dependents pay the deductible for only one plan for the calendar year 2022, and denied respondents' motion to dismiss the proceeding brought pursuant to CPLR article 78, unanimously affirmed, without costs.

The issue raised on this appeal is one of pure statutory interpretation subject to de novo review, and not one requiring deference to the special expertise of respondent

agency (*see Kurcsics v Merchants Mut. Ins. Co.*, 49 NY2d 451, 459 [1980]; *Matter of City of New York v Commissioner of Labor*, 100 AD3d 519, 520 [1st Dept 2012]). Administrative Code § 12-126 (b) (1) provides: "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."

The court correctly determined that Administrative Code § 12-126 (b) (1) requires respondents to pay the entire cost, up to the statutory cap, of any health insurance plan a retiree selects. This interpretation comports with the plain language of the provision as well as its legislative history (*see Matter of Albany Law School v New York State Off. of Mental Retardation & Dev. Disabilities*, 19 NY3d 106, 120 [2012]). Nothing in the statutory text or history supports respondents' interpretation that the provision is satisfied so long as they pay for the costs of one of the health insurance plans offered to retirees, which they have determined to be the Medicare Advantage Plus Plan.

Respondents' contention that they are not required to pay the full cost of $192 per month for the retiree petitioners' current plan, Senior Care, because that cost exceeds the full cost of H.I.P.-H.M.O. "on a category basis" is improperly raised for the first time on appeal. This argument does not raise solely a question of statutory interpretation that may still be addressed (*see Aldrich v Northern Leasing Sys., Inc.*, 168 AD3d 452 [1st Dept 2019]), but involves factual issues that cannot be determined on this record (*see Vanship Holdings Ltd. v Energy Infrastructure Acquisition Corp.*, 65 AD3d 405, 408-409 [1st Dept 2009]). Further evidence is necessary to determine, for example, the meaning of the phrase "on a category basis" and whether, as argued by respondents, coverage for Medicare-eligible individuals constitutes a "category" and costs only $7.50 per month.

We have considered respondents' remaining arguments and find them unavailing.

THIS CONSTITUTES THE DECISION AND ORDER
OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

ENTERED: November 22, 2022

Susanna Molina Rojas
Clerk of the Court

EXHIBIT B

SCHEINMAN
ARBITRATION & MEDIATION SERVICES

December 15, 2022

Via E-Mail only
Renee Campion, Commissioner of Labor Relations
Daniel A. Pollak, First Deputy Commissioner of Labor Relations
Nicole Andrade, Esq. General Counsel of Labor Relations
New York City Office of Labor Relations
22 Cortlandt Street, 14th Floor
New York, NY 10007

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

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.MLC.Medicare Advantage.trans

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

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. Overlayed 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[1]	13,742
Dependents	537,359
Total Covered Lives	**958,420**

Medicare Plans	
Medicare Retirees	177,879
Splits	13,742
Dependents	65,492
Total Covered Lives	**257,113**

Grand Total Covered Lives:	**1,215,533**

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.

[1] 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.[2]

[2] 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%.[3]

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,

[3] 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 generous* 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 deliberatively 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.[4]

[4] 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.[5] 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

[5] 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,

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

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 II). 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, 14th Floor
New York, NY 10007

Alan M. Klinger, Esq.
Dina Kolker, Esq.
Stroock & Stroock & Lavan, L.L.P.
180 Maiden Lane, 33rd 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

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

MFS/sk
City of NY MLC medicare selection.trans

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

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 familiarly 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.

June 24, 2021

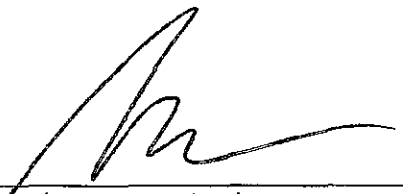
Respectfully submitted,

Martin F. Scheinman, Esq.
Impartial Chairperson of the Tripartite Health Insurance Policy Committee acting pursuant to the parties' request to break their deadlock with my Recommendation as to the selected vendor for the Medicare Advantage Program

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.

June 24, 2021



Martin F. Scheinman, Esq.
Impartial Chairperson of the Tripartite Health Insurance Policy Committee acting pursuant to the parties' request to break their deadlock with my Recommendation as to the appropriate vendor for the Medicare Advantage Program

ATTACHMENT C

SCHEINMAN
ARBITRATION & MEDIATION SERVICES

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