APL-2023-00086

Court of Appeals

State of New York

In the Matter of the Application of

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

Plaintiffs-Respondents,

-against-

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

Defendants-Appellants,

For a Judgment Pursuant to CPLR Article 78.

CORRECTED BRIEF OF *AMICUS CURIAE* NEW YORK CITY MUNICIPAL LABOR COMMITTEE

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STATEMENT OF AMICI CURIAE

Pursuant to Rule 500.23(a)(4)(iii) of the Rules of Practice of the Court of Appeals of the State of New York, Amicus states that no party's counsel contributed content to the brief or participated in the preparation of the brief in any manner. No party or party's counsel contributed money that was intended to fund the preparation or submission of the brief. And no person or entity, other than Amicus, its members and its counsel, contributed money that was intended to fund the preparation or submission of the brief.

PRELIMINARY STATEMENT

For decades, the New York City Municipal Labor Committee ("MLC") and Appellant the City of New York ("City") have negotiated over jointly-administered Citywide health benefits for over a million active and retired City workers and their dependents. Recognizing that we are all retirees in training, labor leaders have consistently and carefully negotiated for comprehensive health plans to expand and preserve retirees' health benefits in the face of steeply rising costs and changing landscapes. To that end, City and MLC historically worked closely together in monitoring and altering plan designs and, when necessary, engaging in public procurements to test the market and select vendors in an effort to protect City employee health benefits. The bargaining process ensures that active and retiree health benefits cannot be changed unilaterally by City.

While MLC's goal has always been to improve benefits, such efforts must grapple with changes to how providers engage the marketplace, evolving federal and state regulation as well as the decades-long steep rise in the cost of healthcare. Despite ongoing efforts to more efficiently provide benefits under City programs—one of the only such programs that continues to provide premium-free coverage for actives and retirees—savings shortfalls and further rising costs have required City and MLC to engage in strenuous efforts to preserve quality healthcare while making needed modifications to all citywide plans. A Tripartite Health Insurance Committee consisting of City and MLC members was established to preserve quality healthcare for active employees, retirees and dependents, with the goal of realizing some $1 billion in savings, with another $600 million in annual savings targeted for Medicare based programs. As contemplated by the agreement establishing the Tripartite Committee, City and MLC negotiated a Medicare Advantage Plan ("MAP") option to continue providing high caliber health coverage for Medicare-eligible-retirees while avoiding more painful changes to the actives' and retirees' programs. The same agreement also called for a procurement to seek savings from a new plan covering active and pre-Medicare retirees. That procurement is currently ongoing.

Against this backdrop, Respondents attempt to block the results of a years-long bargaining and procurement process by MLC and City to implement a

customized MAP that maintains quality care and offers benefit enhancements as the new benchmark plan for Medicare-eligible City retirees and dependents, all while simultaneously accomplishing important savings benefiting retirees and actives alike. In so doing, Respondents have also imperiled City's and MLC's long history of providing collectively bargained for optional plans, at a pay-up, to better serve the diverse needs of participants. Indeed, City's and MLC's selection of a new vendor offering the at-issue custom, no-premium plan for Medicare eligible retirees was but one part of a larger effort to modernize, preserve and improve Citywide health benefits for all. While MLC and City first applied their efforts to significant changes on the active side of the benefits offerings (leaving the retiree plans untouched for some time), that order of operations did not create any grandfathered right to have precisely the same plan offered by the same vendor in exactly the same way in perpetuity. Each renewed agreement between City and its vendors brings consideration of benefits, costs, and the potential that a better arrangement could result from testing the market. That is precisely what MLC and City set out to do with regard to the procurement of a MAP. And, that is what MLC and City are continuing to do in the currently pending procurement for active and pre-Medicare retirees.

The First Department Decision & Order[1] should be reversed because it misinterprets New York City Administrative Code ("Admin. Code") Section 12-126's plain language, purpose, and legislative history as requiring City to fund Medicare retirees' choice of health insurance paid for by City, for life, up to the full cost of the plan only applicable to actives and pre-Medicare retirees. That is not the law.

First, MLC should be permitted *amicus curiae* status in the instant dispute because they, for decades, have negotiated the active and retiree healthcare plans including those at issue in this proceeding, Senior Care and the Alliance MAP. They are therefore uniquely positioned to correct Respondents' mischaracterization of the threshold benefits required to be offered under the Administrative Code, as compared to myriad options and enhancements that can—and have been—negotiated through collective bargaining over the last several decades.

Second, the First Department incorrectly held that Section 12-126(b)(1) obligates City to pay "the entire cost, up to the statutory cap, of any health insurance plan that a retiree selects." First Department Decision & Order at 2. A plain reading of Section 12-126 and its legislative history confirms that City is not

[1] The Supreme Court, Appellate Division, First Department's Decision & Order, dated November 22, 2022 (Appellate Division, NYSCEF No. 40), affirming the Supreme Court, New York County's (Frank, J.) March 3, 2022 Decision & Order On Motion (the "Supreme Court Decision & Order," Supreme Court, NYSCEF No. 216).

required to pay for retirees' choice of plans *ad infinitum*. Instead, City's obligation under Section 12-126 is limited to giving retirees a cost-free healthcare plan that caps City's financial obligation at a level linked to the relevant category of health insurance provided.

Third, the First Department Decision & Order should be reversed because the court failed to analyze Section 12-126(b)(1) *in its entirety* when concluding that it need not address Section 12-126's cap on City's payment obligation. While the court found that Section 12-126 requires City to pay the "entire cost [of health insurance coverage], up to the statutory cap," the court ignored the second half of Section 12-126 which instructs that the applicable cap is determined "on a category basis." Of critical importance to City's arguments below, Section 12-126 states that the statutory cap is "not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." MLC and City argued before Supreme Court that requiring City to pay-up to the significantly higher cost of a plan only available to those ineligible for Medicare fails to recognize that plans available to individuals eligible for Medicare constitute a distinct category.

For the following reasons, MLC supports vacating the First Department Decision & Order, and ordering the petition dismissed in its entirety.

INTEREST OF *AMICUS CURIAE*

MLC and its 102 constituent unions have collectively negotiated and jointly administered various Citywide health benefits available to active and retired New York City public employees and their dependents for more than half a century. As such, they have a real and substantial interest in the outcome of this proceeding.

MLC is organized pursuant to Sections 12-303 and 12-313 of the Admin. Code and is an association created pursuant to a Memorandum of Understanding dated March 31, 1966, signed by representatives of City and certain employee organizations to negotiate benefits of Citywide application. The public employees represented by MLC serve the public welfare, health, and safety on a daily basis.

State and local law empowers MLC and its constituent unions to negotiate over mandatory subjects of bargaining, including retiree health benefits. MLC and City have decades of contractual agreements providing quality healthcare options responsive to the needs of active and retired public employees alike. Indeed, pursuant to law, MLC assent is expressly required for City to enter into a healthcare agreement with providers. MLC therefore has an important role in the procurement process since the specific structure of healthcare plans and options available to retirees has always been determined by collective bargaining. See Municipal Labor Committee v. City of New York, No. 652814/13, 2013 WL 5434005, at *13 (Sup. Ct. N.Y. Cnty. Sept. 30, 2013) (recognizing MLC has an

"equal role" with City in all aspects of the health benefits procurement process). Thus, MLC seeks to be granted *amicus* status to defend the procurement and negotiation processes it participated in and its role in them.[2] MLC is uniquely positioned to distinguish for this Court the benefits which are required under the Administrative Code and those which can be and have been bargained above the lawfully required threshold.

MLC believes that this practical experience in the operations of City labor relations will provide the Court with special assistance and perspective on the issues presented in this case, the resolution of which would have a critical impact on the rights of MLC's constituent unions.

BACKGROUND

MLC assumes the Court's familiarity with the procedural posture and background of this case given the parties' extensive briefing. The factual background set forth below is therefore limited to MLC's and City's role in negotiating MAP.

1. MLC's Role Protecting Health Benefits for City Workers

[2] Supreme Court granted MLC amicus status in support of the City's position (*see* Brief of *Amicus Curiae* of the NYC Municipal Labor Committee in Support of Respondents' Cross-Motion to Dismiss, No. 158815/2021 (Sup. Ct. N.Y. Cnty. Feb. 15, 2022), NYSCEF No. 205).

MLC is an association of City municipal labor organizations comprised of some 102 bargaining units representing approximately 390,000 active City workers, a community of some 250,000 retirees, together with their dependents about 1.1 million covered lives, dedicated collectively to addressing concerns common to its member unions and advocating on issues of labor relations relevant to City workers, of which health benefits are central. See Affidavit of Harry Nespoli, No. 158815/2021 (Sup. Ct. N.Y. Cnty. Oct. 12, 2021), NYSCEF No. 61, ¶ 2.

Over the past half-century, one of MLC's central roles has been to negotiate and jointly administer with City a comprehensive Citywide health benefit program for actives, retirees and their dependents. See id. ¶ 4. The provision of and composition of health benefits is a mandatory subject of bargaining, and may not be unilaterally altered by City (or participating agencies) absent collective bargaining with MLC. See id. (citing N.Y. Civil Service Law §§200, et seq. (the "Taylor Law"); Admin. Code §§12-301, et seq. (the "New York City Collective Bargaining Law")). See id. Accordingly, MLC has both a statutory obligation to address Citywide health benefits and a unique perspective regarding the process by which City health benefits are negotiated and administered. See id.

2. City And MLC's Longstanding Bargaining Over Citywide Benefits

City and MLC have negotiated regarding the provision of health benefits to retirees since the late 1960s. See id. ¶ 8. Indeed, MLC is a party to numerous healthcare agreements with City dating back decades and has formalized roles in the negotiation and administration of Citywide health benefits. See id. MLC's decades of contractual agreements with City have allowed it to leverage the collective market power of some 1.1 million covered lives to provide quality healthcare options that are responsive to the needs of active and retired public employees alike. See Affirmation of Alan M. Klinger, No. 158815/2021 (Sup. Ct. N.Y. Cnty. Oct. 12, 2021), NYSCEF No. 60, ¶ 5.

Since 1960, City has looked to HIP for the provision of healthcare to City employees. See Supreme Court, NYSCEF No. 205 at 8. On February 11, 1965, the Board of Estimate approved under Calendar No. 155 HIP as the Base Plan with City paying 75% of the cost of the HIP-Blue Cross Base Plan for one year and 100% thereafter. See id. On December 5, 1967, City Council approved Local Law 120, designating HIP as the base plan provider against which City's maximum payment obligation was to be measured. The Unions strongly supported the measure as a way to "correct an inequity" existing since Medicare went into effect in 1966 whereby City employees and retirees over 65 would have less than 100%

of their health insurance protection covered by City. See id. The final text excluded language regarding a "basic health insurance plan" because it was not sufficiently defined in the bill and would require City to "be bound" by "an open-ended obligation to pay for coverages which it cannot now possibly anticipate." See id.

In 1985, City Council passed a new bill (Intro # 744-A), which resulted in Section 12-126 in its present form. See id. Section 12-126 provided that HIP (through its HIP-HMO product) would be the Base Plan and City would pay 100% of 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 HIP-HMO on a category basis." No limitation on providers was specified. See id. at 8-9. In addition to Section 12-126, City and MLC entered into collective bargaining agreements designating HIP as the Base Plan with City paying the entire cost of City employee health insurance in an amount not to exceed the Base Plan. Thus, the Unions pushed to expand benefits for both active and retirees through collective bargaining since Section 12-126's inception. See id. at 9.

Since then, City has offered a premium-free option to actives and to retirees: the benchmark plans. See Supreme Court, NYSCEF No. 61, ¶ 9. Any changes to the benchmark plans must be accomplished through collective bargaining and a

jointly-administered process. See id. ¶ 9. The selected vendor and plan need to be accepted by a vote of MLC members, as the instant proposal was here. See Supreme Court, NYSCEF No. 60, ¶ 8. Accordingly, the ultimate acceptability of the proposed plan to MLC is necessary in any procurement. See id.

On July 10, 1992, MLC and City entered into an "Agreement Relating to Procurement of Employee Health Benefits Contracts" (the "1992 Agreement") which memorialized their respective responsibilities. See Supreme Court, NYSCEF No. 61, ¶ 16. The 1992 Agreement provides:

> It is understood and agreed to by the parties hereto that the City and the Unions **shall jointly** continue to participate in all aspects of the procurement process by which **the choice of vendors of collectively bargained health benefits shall be made.**
>
> It is understood and agreed that the parties will continue to bargain over and determine by mutual agreement the terms and conditions of employee health benefits. Appropriate issues shall include, but are not limited to, scope of contracts, their costs, their term(s) and whether annual renewals within the existing contract terms will be made, and if terminated, whether a new procurement should take place. The parties shall also determine on an ongoing basis whether a material change in the terms of any benefits contained in the contract is necessary.

See id. (emphasis added).

The 1992 Agreement squarely sets forth not only that all health benefits and related procurement are to be collectively bargained and administered, but also all

agreements are subject to future collective bargaining—some in connection with major procurements, and others "on an ongoing basis" depending on whether "material change in the terms of any benefits contained in the contract is necessary" (*i.e.*, consideration of an amendment to plan design). Pursuant to the 1992 Agreement, MLC and City jointly prepared several procurements and selected multiple health benefits providers over the years.

This dispute concerns a series of agreements entered into by MLC and City concerning Citywide health benefits, specifically MLC's and City's adoption of MAP for retirees. See id. ¶¶ 19-20. The agreements were negotiated to address rising costs of retiree health benefits and the possibility of using available government subsidies by offering a Medicare Advantage plan[3] to preserve and, where possible, enhance benefits. See id. ¶ 19. The agreement for 2019-2020 reiterated that despite significant savings and improvements being accomplished under the prior health agreement, 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." See id. To that end, the parties established a Tripartite Committee, with a neutral chair to study the issues and make recommendations for City and MLC to consider. See id.

[3] A Medicare Advantage Plan falls within Medicare Part C, and is a Medicare-approved product.

While prior changes to City benefits primarily focused on plans available to active employees,[4] the Tripartite Committee[5] committed to evaluate possible changes (and ultimately recommended such changes) to plans offered to both active employees and retirees. See id. ¶ 20. The procurement specifically asked for plan designs that were equivalent to or improved upon existing retiree benefits, while also reducing costs by taking advantage of federal government funding. See id. ¶ 23. On July 14, 2021, MLC member unions overwhelmingly voted to adopt the Alliance program—a joint bid between EmblemHealth and Empire BlueCross BlueShield which were providing Senior Care—to implement and administer the MAP health insurance plan for City's retirees that mirrored Senior Care with additional benefits. See id. ¶ 29. Per agreement of City and MLC, this new plan was designed to become the benchmark premium-free program as of January 1, 2022. See Supreme Court, NYSCEF No. 60, ¶ 6. Retirees hesitant to move to the new plan immediately were allowed to opt-out and remain in their current plan—

[4] That does not mean, however, that the retiree benchmark plan has never changed. In 2004, the medical benefit deductible was increased to $50 and the hospital inpatient deductible per admission was increased to $300, with a maximum of $750. See Supreme Court, NYSCEF No. 61, ¶ 14; Supreme Court, NYSCEF No. 62 at 132. These increases are in addition to the deductible charged by Medicare, which adjust (generally upward) each year.

[5] The collectively bargained health agreement that formed the Committee also specifically contemplated that the Committee would consider and pursue the adoption of a Medicare Advantage benchmark plan for eligible retirees.

some at no additional cost due to various alternatives with different pricing, and some requiring a contribution towards a premium. See id.

As indicated above, the entire Citywide health benefits plan is subject to discussion and, where deemed appropriate, through collective bargaining, change. See id. Supreme Court's Decision & Order acknowledged as much, providing that "respondent was well within its right to work with the Municipal Labor Council to change how retirees get their health insurance." Supreme Court Decision & Order at 2. While numerous changes have been made over the years with regard to the active employee plans (which includes pre-Medicare retirees), one example of a change to the current Medicare benchmark plan—Senior Care—was an increase in deductibles charged by Senior Care. See Supreme Court, NYSCEF No. 61 ¶ 14. In 2004, the medical benefit deductible was increased to $50 and the hospital inpatient deductible per admission was increased to $300, with a maximum of $750. See id. These increases are in addition to the deductibles charged by Medicare, which adjust (generally upward) each year. See id.

Accordingly, each renewed agreement between City and its vendors brings consideration of benefits, costs, and the potential that a better arrangement could result from testing the market. See Supreme Court, NYSCEF No. 60, ¶ 7. That is

precisely what City and MLC set out to do with respect to the procurement of MAP. See id.

3. MLC'S Involvement in the Negotiated Acquisition

Pursuant to the 1992 Agreement, the evaluation committee for the Negotiated Acquisition comprised eight members, four from City and four from MLC ("Evaluation Committee"). Harry Nespoli, Chair of MLC, appointed the MLC members, each of whom completed the required conflict of interest forms and independently scored the various responses throughout the acquisition process. See Supreme Court, NYSCEF No. 61, ¶ 24. On behalf of MLC and City, the Evaluation Committee conducted the Negotiated Acquisition over more than nine months, evaluating proposals according to the solicitation, issuing questions to offerors, attending presentations by offerors, and assessing a series of best and final offers. See id. ¶ 25. During that public process, without divulging confidential information, MLC continued to negotiate with City and provide updates to its member-unions. See id. ¶ 26. Those unions, in turn, provided information to and relayed questions and concerns from their retirees to MLC. See id.

After careful consideration, the Evaluation Committee recommended that City award the contract to the Alliance, subject to ratification by MLC's member

unions. See id. ¶ 27. Once the proposed vendor and program terms were set, detailed information regarding the winning bid was presented to MLC-member unions. See id. ¶ 28. The unions were also provided an opportunity to ask questions and raise concerns. See id. Access was provided to expert consultants and to the Alliance itself to clarify and explain. See id. Many unions found it relevant that the Alliance program was being offered by the same trusted incumbent providers that offered the Senior Care plan.

MLC's member unions met on July 14, 2021 to vote on whether, under such terms and with the selected vendor, MLC would approve the adoption of a custom Medicare Advantage program for represented workforces. See id. ¶ 29. MLC members voted overwhelmingly in favor of adopting the Alliance program to lead the transition of City's retirees to a Medicare Advantage health insurance plan. See id.

Understanding that change is hard, MLC and City planned to implement MAP alongside Senior Care, at a pay-up for those that wanted to decide whether to commit to a MAP. Shortly before the planned implementation date for the program, Respondents brought the underlying challenge. The Supreme Court's, and then the First Department's, decisions resulted in a delay and then a restriction on MLC's and City's ability to continue the existing most popular plan—Senior

Care—alongside the new MAP at a cost. In light of those decisions, MLC worked to try to preserve plan choice. To that end, MLC urged City Council to amend the Administrative Code to revert to MLC and City's prior understanding that optional plans could be offered to retirees at a pay-up from the benchmark plan. Respondents thwarted that effort by stoking unwarranted public outrage, ensuring that City would no longer offer optional plans that cost more than the benchmark, premium-free plan.

Given the considerable delay caused by retirees' challenge to the Alliance MAP, Empire and, as a result, the Alliance, pulled out of the deal, ending its viability on July 15, 2022.

4. New Challenges to City's Map Plan

With the withdrawal of the selected vendor, City and MLC returned to the bargaining table. Arbitrator Martin Scheinman—who serves as the Impartial Chair of the Tripartite Health Insurance Policy Committee—presided over an arbitration between City and MLC regarding whether negotiations should be pursued with the remaining qualified Negotiated Acquisition bidder, Aetna. Arbitrator Scheinman stressed the imminent depletion of the Stabilization Fund[6] given rising healthcare

[6] The Stabilization Fund is a fund jointly controlled by the City and MLC, providing significant assistance to MLC and City as a funding mechanism for various benefits. As part of the Tripartite process it was agreed that any savings resulting from the MAP would go to support the Stabilization Fund, which, among other items, provides benefits to union actives and retirees.

costs, stating: "circumstances have evolved to threaten the sustainability of robust premium free benefits for actives and retirees," and that "[f]ailure to have this agreement ratified shall result in finding another revenue source which, inevitably, shall lead to premium contributions." Supreme Court, Index No. 154962/2023, NYSCEF No. 61 at 17, 27, 30. As illustrated by Arbitrator Scheinman, if savings through a MAP are not realized—one important component of an overhaul—then more painful changes may be needed elsewhere, including for pre-65 retirees.

To continue providing quality healthcare coverage, MLC and City negotiated a MAP with Aetna that complied with the Supreme Court Decision & Order, and took into account the concerns raised by retirees in these proceedings. The parties did so with an agreement to offer a single comprehensive plan where no premium costs are passed to retirees and with extremely limited prior authorizations—indeed, far fewer than they experienced while in active status, and even fewer than what had been contemplated in the earlier Alliance construct.

Now, Respondents are challenging the new Aetna MAP on the basis that all MAPs are objectionable, no matter what the terms. See Bentkowski, et al. v. The City of New York, et al., 154962/2023 (Sup. Ct. Aug. 11, 2023), *on appeal at* 2023-04103 (1st Dep't 2023).

POINT I – Section 12-126 Does Not Require City To Pay For More Than One Insurance Plan

For the reasons stated below and in City's Appellate Brief, the First Department Decision & Order erroneously concluded that Section 12-126 requires City to pay for more than one insurance plan, if offered. See First Department Decision & Order at 2; see also Appellate Division, NYSCEF No. 10 .

Section 12-126 sets a floor for the requisite health benefits that City must provide, subject to collective bargaining which determines the plan design for those benefits and can provide for a choice of benefits. MLC and City have historically, through collective bargaining, set the baseline, premium-free plan for Medicare-eligible retirees. See Supreme Court, NYSCEF No. 205 at 12. In doing so, they have negotiated for Senior Care, a Medigap Plan which is a more robust than, for example, the HIP VIP Premier (HMO) plan that is one of several options (including Medicare Advantage plans) besides Senior Care available to retirees. See Supreme Court, NYSCEF No. 61 at 3-5; Supreme Court, NYSCEF No. 205 at 12. As the legislative history in City's appellate brief demonstrates, the bargaining process gives MLC and City an avenue to provide enhanced health plans that surpass City's minimum obligation under the Administrative Code. See Appellate Division, NYSCEF No. 10 at 14-15.

Respondents' unsupported assertion before the First Department that only allowing for one premium-free option under Section 12-126 results in City funding

a plan with worthless benefits is an affront to the bargaining process. See Appellate Division, NYSCEF No. 36 at 4-5. Contrary to Respondents' insinuation, Section 12-126 does not give City and MLC *carte blanche* to implement an unfavorable plan. Instead, the legislative and bargaining history since 1965 confirms that the bargaining process gives MLC and City an avenue to provide enhanced health plan options and benefits. At a time when HIP was too restrictive because it only provided one non-profit option, MLC pushed to expand City's offerings (including with Medicare Part B coverage). Using bargaining to protect retirees' health coverage is playing out the same way now. To address skyrocketing healthcare costs, City and MLC initially agreed to provide MAP and HIP VIP premium-free, with the option to pay-up for Senior Care as a cost-effective way to provide the same or better benefits to retirees, while leaving open the option to retain the current most popular plan. Union leaders, many of whom are close to retirement age, were careful to protect retirees' health benefits and provide a plan that was comparable to Senior Care. Decades of bargaining between City and MLC therefore continue to ensure solid health plans for all City workers.

By interpreting Section 12-126 to require City to cover the cost of all bargained for optional plans up to the cost of the active plan, the Appellate Court

limited the ability of City and MLC to negotiate for and implemented optional plans.

POINT II – Section 12-126 Only Obligates City To Pay-Up To A Statutory Cap for Medicare-Eligible Retirees

Even assuming the First Department did not err in finding that Section 12-126 requires City to pay for optional plans, it nevertheless incorrectly ignored City's argument that Section 12-126's proper cap is the HIP HMO offered to Medicare eligible retirees: HIP VIP HMO. In that regard, the First Department failed to consider Section 12-126 in its entirety, stating that "Respondents' contention that they are not required to pay the full cost of the $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." First Department Decision & Order at 2. As set forth below, both City and MLC raised this argument before Supreme Court, rendering it ripe for adjudication. At a minimum, this case concerns questions of statutory interpretation that may be raised for the first time on appeal. See Appellate Division, NYSCEF No. 10 at 39.

The cardinal rule of statutory construction is "to discern and give effect to the Legislature's intention." Avella v. City of New York, 29 N.Y.3d 425, 434 (2017). To do so, "courts should construe unambiguous language to give effect to

its plain meaning." Id. (cleaned up). In that regard, this Court's reasoning that "all parts of a statute are intended to be given effect and that a statutory construction which renders one part meaningless should be avoided," is critical. Id. (cleaned up). That is further supported by this Court's observation that courts must therefore consider "the statute as a whole, and effect and meaning must, if possible, be given *to the entire statute and every part and word thereof*." Lynch v. City of New York, 40 N.Y.3d 7 (2023) (emphasis added) (cleaned up); see also People ex rel. Molinaro v. Warden, Rikers Island, 39 N.Y.3d 120, 126 (2022) (discussing well-established rules of construction requiring "we give meaning to all the words of a statute and read the statute as a whole, harmonizing all of its provisions" (cleaned up)).

The need to harmonize all words in a statute is paramount where, as here, Supreme Court and First Department ignored the key second part of the very sentence in Section 12-126 that they were interpreting, which qualified the first part of the sentence. The First Department Decision & Order thereby failed to give meaning to all the words chosen by City Council. See Golden v. Koch, 49 N.Y.2d 690, 694 (1980) (stating that under "traditionally accepted standards of statutory construction," courts must "read [a statute] as a whole" and consider "each word").

Brookford, LLC v. New York State Division of Housing and Community Renewal, 31 N.Y.3d 679 (2018), is instructive. There, this Court considered whether the Division of Housing and Community Renewal correctly determined that a tenant and non-tenant's income, as reported on their joint tax returns, could be apportioned for purposes of determining whether their income exceeded the applicable threshold under the Rent Regulation Reform Act of 1993. The statute allows for the deregulation of a housing accommodation when, *inter alia*, the "total annual income" exceeds $175,000 in the two calendar years preceding the filing of an ICF. RCL § 26-403.1(a)(2). "Total annual income means the sum of the annual incomes of all persons who occupy the housing accommodation as their primary residence other than on a temporary basis." RCL § 26-403.1(a)(1). The Court of Appeals rejected the landlord's argument that total annual income could not be apportioned between the tenant and non-tenant because a joint tax return results in joint tax liability. The Court reasoned that finding in favor of the landlord "would mean that total annual income may include those persons who do not occupy the housing accommodation as their primary residence. Such a construction, resulting in the nullification of one part of the [statute] by another, is impermissible, and violates the rule that all parts of a statute are to be harmonized with each other." Matter of Brookford, LLC, 31 N.Y.3d at 686-87 (cleaned up).

Likewise, here, the First Department erroneously excised the second half of Section 12-126(b)(1) from its analysis when holding that Supreme Court "correctly determined that the 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." Appellate Division, NYSCEF No. 40 at 2. Section 12-126(b)(1) states that the statutory cap "not . . . exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." Id. As set forth below, "[o]n a category basis" refers to the HIP VIP HMO designed for Medicare eligible retirees. Determining whether City violated Section 12-126 by declining to pay $192 per month for retiree petitioners' Senior Care plan necessarily requires consideration of whether Section 12-126's statutory cap is $776 for Medicare eligible and ineligible enrollees, as Respondents contend, or less for *solely* Medicare eligible enrollees, as City contends. The First Department declined to engage in that analysis, abdicating its responsibility to analyze Section 12-126 as a whole.

The First Department's failure to consider City's interpretation of the phrase "on a category basis" in Section 12-126 because it believed it was raised for the first time on appeal is also unsupported. MLC argued before Supreme Court that "Petitioners' motion for summary judgment also rested on the unsupported proposition that City must pay up to a 'statutory cap' of $776, or the cost of the HIP-HMO plan." See Supreme Court, NYSCEF No. 205 at 12-13. The $776

figure represents the 2021 monthly cost of an *active* plan—*i.e*., a "Non-Medicare Single" HIP-HMO plan. See id. City also argued before Supreme Court that "the statutory cap for Medicare-eligible retirees was the HIP HMO plan actually available to them as a separate category of insured." Appellate Division, NYSCEF No. 38 at 25 (citing Supreme Court, NYSCEF No. 212). These arguments before Supreme Court demonstrated that it has long been understood that the HIP rate for active employees—a full coverage plan—is not an appropriate reference for consideration of any obligation to provide plans for Medicare-eligible retirees, a supplemental plan. Rather, City and MLC have agreed over the years through collective bargaining upon a "pay-up" cost above the "benchmark" amount up to which City would contribute to the cost of retiree plans that it offered.

As previously pointed out, there are pre-Medicare retirees and Medicare-eligible retirees participating in City health plans. For pre-Medicare retirees who participate in the active plans, City pays the full cost of the HIP-HMO plan for active employees or, pursuant to collective bargaining agreements, certain other plans available to actives and pre-Medicare retirees and dependents. However, once a retiree or dependent becomes eligible for Medicare, they fall into a different category. Medicare becomes primary, with City paying for the Medicare-covered component of coverage by reimbursing the cost of both the standard Medicare Part B premium and the income based component (IRMAA) of that premium such that

basic Medicare coverage is likewise premium free. See Admin. Code § 12-126(b)(1). Senior Care is a medigap supplemental plan and therefore *not of the same category* as the comprehensive HIP-HMO plan referenced by Respondents. One cannot enroll in Senior Care without being enrolled in Medicare. MLC and City have historically, through collective bargaining, set the baseline, premium-free plan for Medicare-eligible retirees, currently Senior Care. In doing so, they have provided a plan that is more robust than the corresponding HIP HMO product for Medicare eligible retirees—i.e., HIP VIP Premier (HMO). The new MAP plan tracks Senior Care and is also more robust than the HIP VIP plan and some others currently available, at a pay-up to retirees. Just like Senior Care, the new MAP plan also requires that members enroll in Medicare. Just like with Senior Care, MAP is also paid for by City through the Medicare Part B reimbursement, plus any per member cost charged by the MAP provider. The only difference in how City provides coverage under the MAP is that a Medicare Advantage plan taps into additional federal subsidies which a medigap plan such as Senior Care cannot.

The "pay-up" cost of other plans offered to Medicare-eligible retirees has always been determined in relation to the collectively bargained baseline plan. Take the range of health plans offered by City as of January 1, 2022. See NYC Office of Labor Relations, NYC Health Benefits Program, Health Plan Rate Chart for Retirees – January 2022, available at:

https://www1.nyc.gov/site/olr/health/summaryofplans/health-ratechart.page (last accessed Nov. 5, 2023). City currently offers twelve Monthly Medicare health plans for individuals and families. See id.; *supra* at 13. In addition to Senior Care, the plans offer a mix of no-premium and pay-premium options available to retirees. Tellingly, most of these amounts (even when the base cost of Senior Care is included) are less than Respondents' stated $776 benchmark rate. If Respondents were correct in their analysis it would create a major impediment to negotiating a variety of optional plans as City would be obligated to pay the full Part B reimbursement and the full cost of any plan up to $776 for each retiree, an amount even exceeding what is due under the Administrative Code for actives (who do not benefit from the Part B reimbursement). Rather, all concerned have long recognized that Medicare supplemental plans fall into a different "category" than full programs for active workers. Thus, Senior Care would now simply be another of these plans that is offered as an alternative to the premium-free MAP plan, which meets City's legal obligation to provide at least one premium-free plan. By continuing to offer a comprehensive premium-free option for retirees in the MAP, City continues to comply with the Administrative Code and its collective bargaining obligations.

Affirming the Decision & Order's holding, that the benchmark for Medicare-eligible individuals is the full cost of the active plan, would create an

imbalance in funding by which more money is available to Medicare eligible retirees than actives and other retirees. It would oblige City to pay-up to the cost of the active plan *plus* the full cost of the Part B premium for Medicare eligible retirees, but not for actives and pre-Medicare retirees. Section 12-126 does not contemplate such unevenness in funding. Rather, it provides that each category be provided premium-free access to the HIP HMO plan corresponding to their eligibility: (1) pre-Medicare individual, (2) pre-Medicare with family, and (3) Medicare-eligible.

Regardless, the proper construction of Section 12-126 may be considered by this Court for the first time on appeal because it raises questions of pure statutory interpretation. See Appellate Division, NYSCEF No. 10 at 38-39.

POINT III – Respondents Do Not Have A Unilateral Right To Lifetime Medigap Insurance Based On Past Practice

City's practice of paying for certain health insurance options that cost below what they identify as the statutory cap is not a "binding concession" that Section 12-126 requires City to continue to pay for Medigap plans. See Appellate Division, NYSCEF No. 36, at 41-43. That argument entirely ignores the bargaining process whereby City and MLC negotiated benefits beyond the minimum provided by law. Accordingly, the requirement of Section 12-126 cannot be discerned by reference to benefits provided based upon collective bargaining. Nothing in Section 12-126, or the CBAs, suggest that Respondents' healthcare benefits would be set in stone in perpetuity.

In that regard, the CBAs between MLC and City governing Citywide healthcare benefits, including for retirees, have always been subject to negotiation and change. For example, the 1992 Agreement in which City and the Unions agreed to "continue to bargain over and determine by mutual agreement the terms and conditions of employee health benefits" evidences an intent to jointly prepare and select multiple health benefits providers. Similarly, myriad collective bargaining agreements between City and MLC also contemplate changes to Citywide health benefits. See, e.g., 1995 Municipal Coalition Memorandum of Economic Agreement, Supreme Court, NYSCEF No. 35 (". . . the parties may

negotiate a reconfiguration of this package . . ."); Agreement between the Board of Education of the City School District of the City of New York and Council of Supervisors and Administrators, Supreme Court, NYSCEF No. 36 ("Any program-wide changes to the existing basic health coverage made either by the DOE and CSA or city-wide, by the Municipal Labor Committee and the City, will be expressly incorporated into and made a part of this Agreement"); Agreement between the Board of Education of the City School District of the City of New York and United Federation of Teachers, Supreme Court, NYSCEF No. 42 ("The Board, the Union and the City of New York ('City') continue to discuss, on an ongoing basis the Citywide health benefits program covering employees represented by the Union and employees separated from service. Any program-wide changes to the existing basic health coverage will be expressly incorporated into and made a part of this Agreement."); Detectives' Endowment Association 2008-2012 Agreement, Supreme Court, NYSCEF No. 37 (". . . retirees shall have the option of changing their previous choice of health plans. This option shall be exercised in accordance with procedures established by the Employer"). The record shows that City and MLC have historically used the bargaining process to modify retirees' health benefits, just like they did here. That Respondents are unhappy with the result in this instance does not transform decades of past practice into some form of statutory mandate.

Respondents' illogical assertion that a past practice equates to a unilateral right to have a health plan of their choosing is equally at odds with the Taylor Law. A past practice under New York's labor laws is designed to identify terms and conditions of employment, like Citywide health benefits, that an employer cannot unilaterally change absent bargaining. See N.Y. Civ. Serv. Law § 209-a. As long as City and MLC are bargaining over health benefits, Respondents do not have a right to interfere with that process and claim an unchangeable right to a health plan of their choosing.

CONCLUSION

Wherefore, proposed *amicus curiae* MLC respectfully submits that the Court should reverse and deny the petition in its entirety.

Dated: New York, New York
November 21, 2023

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WORD COUNT CERTIFICATION

I hereby certify pursuant to 22 NYCRR §500.13(c) that the foregoing brief was prepared on a computer using Microsoft Office Word, using typeface Times New Roman, 14.

The total number of words in this brief is 6,828.

Dated: New York, New York
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APL-2023-00086

STATE OF NEW YORK
COURT OF APPEALS

In the Matter of the Application of

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

Plaintiffs-Respondents,

-against-

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

Defendants-Appellants,

CORRECTED AFFIRMATION OF SERVICE

DAVID KAHNE, an attorney duly admitted to practice before the courts of the State of New York, hereby affirms the following to be true under penalty of perjury:

1. I am a member of the firm Steptoe & Johnson LLP, 1114 Avenue of the Americas, New York, NY 10036, counsel for proposed Amicus Curiae the New York City Municipal Labor Committee in connection with the above-referenced appeal.

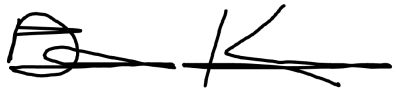
2. On November 21, 2023, I caused to be served a true and correct copy of (1) the Notice of Motion for Leave to File Amicus Curiae Brief on Behalf of New York City Municipal Labor Committee; (2) the Affirmation in Support of same; and (3) Corrected [Proposed] Brief Amicus Curiae of the

Municipal Labor Committee via Federal Express, by depositing a true copy thereof, enclosed in a wrapper addressed as shown below, into the custody of Federal Express for overnight delivery, prior to the latest time designated by the service for overnight delivery.

New York City Law Department; ATTN: Chloe Moon 100 Church St., New York, NY 10007

Walden Macht & Haran LLP; ATTN: Jacob Gardener 250 Vesey Street, 27th Floor New York, NY 10281

Dated: November 21, 2023
New York, NewYork



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