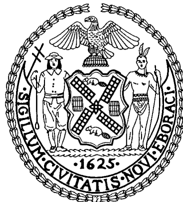

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February 16, 2022

Via NYSCEF
Justice Lyle E. Frank
Supreme Court of the State of New York
60 Centre Street
New York, New York 1007

Re: NYC Organization of Public Service Retirees, Inc. et al. v. Renee Campion et al
Index No: 158815/2021
Law Dept. No.: 2021-028140

Dear Justice Frank:

In accord with Your Honor's email, attached please find The Alliance's Amicus Brief in Support of Respondents' Cross-Motion to Dismiss as emailed on February 15, 2022.

We thank the Court for its attention to this matter.

Respectfully submitted,
/s/__________________
Rachel M. DiBenedetto
Assistant Corporation Counsel

cc: **(VIA NYSCEF)**

All counsel of record

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

---------------------------X

In the Matter of the Application of

LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOLVERTON, ED FERRINGTON, MERRI TURK LASKY, PHYSLLIS 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,

Petitioners,

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, and the CITY OF NEW YORK

Respondents.

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Index No. 158815/2021

BRIEF *AMICUS CURIAE* OF THE ALLIANCE IN SUPPORT OF RESPONDENTS' CROSS-MOTION TO DISMISS

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Pursuant to the Court's oral order at the February 7, 2022 status conference, The Alliance respectfully submits this brief as *amicus curiae* in support of Respondents' Cross-Motion to Dismiss, NYSCEF No. 95.

PRELIMINARY STATEMENT

Petitioners ask the Court to override three decisions made by Respondents about the City's new NYC Medicare Advantage Plus Plan ("MAP"), a new premium-free plan for City retirees. Specifically, Petitioners purport to challenge: (1) the City's decision to adopt the MAP; (2) the City's choice to use an opt-out process for enrollment in the MAP; and (3) the City's decision to adopt a monthly premium charge for some plans *other* than the MAP, including the GHI-BCBS Senior Care Plan ("Senior Care").

As the Court is aware, all three decisions reflected the exercise of substantial discretion and judgment by the City and the Municipal Labor Committee ("MLC"). Indeed, those decisions were the fruit of years of coordination and negotiation between the City and the MLC, pursuant to longstanding collective bargaining arrangements, designed to address the long-term shape and scope of the City's healthcare system. The MAP was chosen through a negotiated acquisition process through which the City bargained for, and received, a custom health plan that met its needs. The MAP's selection was subsequently ratified by vote of the full MLC. The *process* resulting in the MAP's adoption was thus considered and deliberative (and anything but capricious). Nor was the *substantive* choice of the MAP irrational. Petitioners agree that the MAP allows the City to tap into federal funding sources that will generate significant health-care cost savings and help stabilize the City's finances—an eminently rational goal.

Petitioners' remaining contention is that the City's decisions were contrary to law. The Court has asked the parties to focus on one specific issue in the upcoming oral argument—New York City Administrative Code Section 12-126 ("Section 12-126"). Some Petitioners have

signaled that they wish to opt out of the MAP and remain in their current plan, Senior Care. But they object to paying a monthly premium for Senior Care, and claim that Section 12-126 precludes the City from imposing those charges, in part because Senior Care was previously premium-free.

Petitioners' argument finds no support in the plain text of Section 12-126, its legislative history, or past practice.

Section 12-126 does not require the City to offer retirees any particular health plan, any particular number of health plans, or purport to limit the City's discretion (and that of the MLC and its constituent member unions) to craft an array of health-care offerings with different premium contributions. All Section 12-126 requires is that the City pay "the entire cost of health insurance coverage" for retirees (up to a cap). "Health insurance coverage" is, in turn, defined as *a* (singular) health insurance program. The MAP is unquestionably a health insurance program, and the City is covering "the entire cost" of it, because the MAP is premium-free to retirees. So the City is doing precisely what Section 12-126 mandates—paying "the entire cost" of "health insurance coverage" for retirees—and the provision otherwise has nothing to say about the City's choice to charge a premium for Senior Care or any other plan.

The legislative history of Section 12-126 confirms that the provision has nothing to say about *how many* premium-free offerings the City need offer, or how the City may, in its discretion adjust existing offerings. (It also confirms, as Judge Koeltl of the U.S. District Court for the Southern District of New York has held, that Section 12-126 does not limit the City's discretion to adjust *non*-premium aspects of its health care options, like co-pays or deductibles.) Petitioners' interpretation would also be absurd in light of past practice, given that the City has, for years, offered retirees a wide variety of plans—some premium-free, and some with associated premiums—and is planning to continue to do so after the MAP is implemented.

Petitioners have simply not met their burden to show that the considered choices of the City and the MLC, and the MAP's selection, violate Section 12-126. For that reason, and the others set out in Respondents' moving papers, the City's decision to offer the MAP premium free and not Senior Care is not arbitrary or capricious. The Alliance thus supports dismissal of this proceeding.[1]

ARGUMENT

I. The City's Decisions Regarding MAP Implementation Are Rational

The Petition, NYSCEF No. 1, asks the Court to overturn three discretionary decisions. Specifically, Petitioners ask the court to reverse, vacate, set aside, and enjoin: (1) the City's decision to implement the MAP; (2) the City's decision to enroll retirees in the MAP via an opt-out process, rather than an opt-in system; and (3) the City's decision to add premiums to several non-MAP plans that were previously premium-free.

All these decisions—crafting and selecting the MAP, using an opt-out enrollment process, and whether to charge premiums for various plans—were made in consultation with the MLC over the course of years of negotiations. *See, e.g.*, NYSCEF No. 61, ¶¶ 19-29. All three decisions were plainly discretionary exercises of judgment by the City and MLC. And all three decisions were entirely rational. Review of such discretionary decisions is highly deferential, "for it is not the role of the courts to weigh the desirability of any action or choose among alternatives." *Save Am.'s Clocks, Inc. v. City of New York*, 33 N.Y.3d 198, 207 (2019) (quoting *Matter of Friends of P.S. 163, Inc. v. Jewish Home Lifecare, Manhattan,* 30 N.Y.3d 416, 430 (2017)). "The courts cannot interfere unless there is no rational basis for the exercise of discretion or the action is without sound

[1] As a result of the Court's guidance at the February 7 status conference, The Alliance focuses in this brief only on Section 12-126. The Alliance agrees with the City's other contentions, *see* NYSCEF Nos. 79 and 201, and supports dismissal on those grounds as well.

basis in reason and taken without regard to the facts." *Id.* (quoting *Matter of Pell v. Board of Educ. of Union Free School Dist. No. 1 of Towns of Scarsdale & Mamaroneck, Westchester County,* 34 N.Y.2d 222, 231 (1974) (internal modifications omitted)).

Petitioners *disagree* with the selection of the MAP and the use of an opt-out enrollment process; that much is clear. But as the City and MLC have observed, petitioners have not identified any *irrationality* in those fundamentally discretionary decisions. *See* NYSCEF No. 79 at 8-9; *see also* NYSCEF No. 60, ¶¶ 18-28.

As to the MAP generally, the City has offered Medicare Advantage plans as an option for retirees for years. There is nothing irrational or arbitrary about offering such plans. The City's decision to charge a premium for Senior Care, but not for the MAP, is also entirely rational. Petitioners *concede* that moving retirees to the MAP will save the City a *substantial* sum of money—$600 million annually. *See* NYSCEF No. 189 at 14, 28. That concession effectively ends the inquiry; decisions by a government based on a desire to protect the public fisc have repeatedly been deemed rational by New York courts, including the Court of Appeals. *See, e.g., Matter of L&M Bus Corp. v New York City Dept. of Educ.*, 17 N.Y.3d 149 (2011) (adoption of bussing plan designed to hold down costs was a "legitimate exercise of DOE's business judgment"); *Matter of Global Tel*Link v. State of N.Y. Dept. of Correctional Servs.*, 70 A.D.3d 1157 (3d Dep't 2010) (decision to award a contract to one bidder over the other based on lower cost was rational). The City's discretionary decision to enroll retirees via an "opt-out" process, rather than an opt-in mechanism, was rational for the same reason (among others)—it will tend to encourage more retirees to join the MAP, and thus tend to increase the City's savings.

Petitioners were and are free to disagree with those choices, and assert that that the City should have pursued its goals in a different way. But such debates about the proper balancing of

interests are properly addressed through the political process. They are not a matter for Article 78 review.

II. The City's Selection of the MAP Does Not Violate Section 12-126

The only remaining question is whether Petitioners have shown that any of the challenged decisions was "affected by an error of law." CPLR 7803(3). They have not.

To start, Petitioners must demonstrate any purported illegality by clear and convincing evidence. *See New York v. City Civil Serv. Comm'n*, 141 Misc. 2d 276, 281 (Sup. Ct., N.Y. Cty. 1988) (petitioners required to demonstrate "by clear and convincing evidence that the [agency] acted . . . contrary to law"); *Walker v. Board of Examiners*, 22 Misc. 2d 345, 348 (Sup. Ct., N.Y. Cty. 1957) (for petitioners to demonstrate agency decision was contrary to law, evidence "must be clear and convincing, not speculative and conclusory").

Petitioners have not come close to carrying that heavy burden. Section 12-126 plainly does not preclude the City from offering a Medicare Advantage program generally, or the MAP in particular. Nor does it address enrollment mechanisms. So the only question is whether the City's choice to designate the MAP as retirees' premium-free option, and to charge premiums for Senior Care and other plans, violates Section 12-126—and it does not.

A. Section 12-126 Does Not Purport to Limit the City's Discretion in Designing, Offering, or Adjusting its Health Plan Offerings.

The City's core argument is that Section 12-126 requires only that the City offer at least one premium-free health insurance option to retirees—not multiple premium-free options, or any *particular* premium-free option. NYSCEF No. 201 at 2. The plain text of Section 12-126 supports that interpretation.

As noted above, Section 12-126 requires the City to "pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents," up to a cap. N.Y.C. Admin. Code

§ 12-126(b)(1). "Health insurance coverage" is defined as follows: "A program of hospital-surgical-medical benefits to be provided by health and hospitalization insurance contracts entered into between the city and companies providing such health and hospitalization insurance." N.Y.C. Admin. Code § 12-126(a)(iv). Section 12-126 thus by its terms requires the City to cover "the entire cost" (to a cap) of *a* (singular) "program of hospital-surgical medical benefits."

Other portions of Section 12-126 confirm that "health insurance coverage" refers to a singular health insurance plan, not multiple plans (or any particular plan). For example, Section 12-126(b)(2)(ii) addresses the situation of deceased firefighter retirees, and provides that where such a retiree "dies and is enrolled *in a health insurance plan*, the surviving spouse shall be afforded the right to *such health insurance coverage* ***and*** *health insurance coverage* which is predicated on the insured's . . . social security act" coverage. This provision clearly contemplates that a single "health insurance plan" is "such health insurance coverage," which is why it is necessary to explain that retired firefighter widows are (unlike other covered persons) also entitled to *other* "health insurance coverage." *Accord* Section 12-126(b)(2)(iv) (same for widows of DOC and sanitation employees).

Here, it is undisputed that the MAP is "health insurance coverage," and the City is paying "the entire cost" of it. That discharges the City's obligations to retirees under Section 12-126.

Now, consider what Section 12-126 *doesn't* say.

1. The provision does not require the City to offer Senior Care, or any specific individual health plan offering. Instead, "health insurance coverage" is defined generically, not by reference to any specific plan. *See* Section 12-126(a)(iv). So Section 12-126 clearly does not command for the City to cover "the entire cost" of any *particular* plan, or even any particular type of plan.

2. Section 12-126 also says nothing about how many health insurance plans the City must offer retirees, or anything about how many premium-free plans must be offered. To the contrary, "health insurance coverage" is explicitly defined as *singular*: namely, "*A* program of hospital-surgical medical benefits." That is why, as explained above, making the MAP (such a program) premium-free to retirees satisfies Section 12-126's requirement to cover "the entire cost" of "health insurance coverage."[2]

3. Section 12-126 does not limit the City's discretion to modify health insurance plans, offer new ones, or change premium contribution rates for either. Such decisions can and are often made pursuant to discussions and negotiations between the City and the MLC. *Supra* at 1. Indeed, Section 12-126 clearly serves as a floor, and not a ceiling; the City is free to contribute *more* to the cost of health care than Section 12-126 requires, as may be collectively bargained or otherwise agreed. But nothing in *Section 12-126* mandates any particular result, much less the particular result urged by Petitioners.

All of this forecloses Petitioners' position as a matter of law. "[A] court cannot amend a statute by inserting words that are not there, nor will a court read into a 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) (quoting McKinney Practice Commentary, Stat. Law § 363). Section 12-126 does not require the City to offer multiple premium-free plans, any particular premium-free plan, or oblige the City to offer the same premium-free plans in perpetuity. The Court should reject Petitioners'

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[2] Petitioners' focus on the plural "contracts" and "companies" in the definition of "health insurance coverage," NYSCEF No. 189 at 9-10, does not change the analysis, because a singular health insurance plan/program can and often does involve multiple companies and contracts. The Court need not go far to find one – Senior Care *itself* involves multiple "companies" (EmblemHealth and Empire BlueCross BlueShield) and "contracts." The situation was the same around the time that Section 12-126 was enacted. *See* NYSCEF No. 192 at 24 (noting, as of 1965, three insurance plans made up of five coverage components provided by five different companies).

invitation to read such provisions into Section 12-126.

B. The Legislative History of Section 12-126 Demonstrates that It Requires Only That the City Provide at Least One Premium-Free Insurance Option

While the plain text of Section 12-126 is clear in itself, the legislative history of Section 12-126 further confirms that the City is not required to cover "the entire cost" of all of the City's plan offerings. To the contrary, as laid out below, then-Mayor John Lindsay *rejected* an earlier version of the law that became Section 12-126 that would have obliged the City to pay for the cost of "any basic health insurance plan." Section 12-126, as enacted, contained no such language.

1. The City Offers Retirees Multiple Health Insurance Plans in 1965

The impetus for Section 12-126 began two years before its adoption. On February 11, 1965, the New York City Board of Estimate[3] (the "Board of Estimate") adopted a resolution (Cal. No. 155) to offer a choice of three health insurance plans[4] to "certain uniformed forces" of the City government based on collective bargaining agreements between those City employees and the City. NYSCEF No. 192 at 32-34. The resolution changed the City's previous health insurance regime, which consisted of the City paying "up to 50 per cent of the premiums" of one health insurance plan (a H.I.P. plan). *Id.* at 23. In addition to offering a choice of health insurance plans, Cal No. 155 also noted that collective bargaining had resulted in an agreement for the City to pay a larger percentage of the "total payment for health and hospital insurance"—75 percent of the

[3] The New York City Board of Estimate was a New York City governmental body, made up of the Mayor, the City Comptroller, the President of the City Council, and the Borough Presidents of the five boroughs; it was abolished in 1990 as part of U.S. Supreme Court-mandated revisions to the City Charter. *See Board of Estimate of City of N.Y. v. Morris*, 489 U.S. 688 (1989) (finding Board of Estimate unconstitutional); Alan Finder, *New York City Charter Revision Approved by Department of Justice*, N.Y. Times (Dec. 14, 1989), https://www.nytimes.com/1989/12/14/nyregion/new-york-city-charter-revision-approved-by-justice-department.html.

[4] The resolution specifies that the plans shall include "H.I.P.-Blue Cross, . . . G.H.I.-Blue Cross and Blue Cross-Blue Shield-Major Medical." NYSCEF No. 192 at 33.

premium starting January 1, 1965 and 100 percent of the premium starting January 1, 1966 *Id.* at 32.

On December 14, 1965, the Board of Estimate adopted another resolution (Cal. No. 292), which extended this three-plan choice to retirees and all other City employees on similar terms, but with effective dates of January 1, 1966 for the 75 percent coverage and January 1, 1967 for the 100 percent coverage of "regular premiums." *Id.* at 27. The resolution, recognizing the increased risks for insurance companies from insuring retirees, provided that insurance companies that contracted with the City could charge "supplemental premiums" for retirees. *Id.*

2. The City Requires Over-65 Employees and Retirees to Pay Medicare Premiums in 1966

On July 1, 1966, Medicare went into effect. In response, the City modified its health insurance plans to remove benefits duplicated by Medicare. *Id.* at 21. All employees and retirees over 65 had to enroll in Medicare Part B to obtain those benefits, which required them to pay a $3/month premium. *Id.* Retirees, unions, and legislators then began a push for the City to cover this $3/month cost. *See, e.g., id.* at 19 (retiree letter); 20 (union letter); 21 (newspaper coverage of legislators).

3. The City Council's Attempt to Fully Cover "Any Basic Health Insurance Plan" Fails

In response to this public feedback, the City Council proposed a bill on July 11, 1967 (Int. No. 430), which provided that the City would cover "the entire cost of *any* basic health insurance plan . . . to all . . . members of the New York city employees' retirement system." *Id.* at 6 (emphasis added). The bill would have defined "basic health insurance" to "include . . . premium payments for coverage under [Medicare]." *Id.*

Mayor Lindsay disapproved of the proposed bill and returned it to the City Council. Mayor Lindsay concluded that the proposed legislative language obligating the City to cover "the entire

cost of any basic health insurance plan," *id.* at 8, was objectionable because the term "basic health insurance" was nowhere clearly defined. That could, Mayor Lindsay reasoned, lead to a scenario where "the City would be bound to an open-ended obligation to pay for coverages which it cannot now possibly anticipate." *Id.*

4. The City Adopts Local Law 120 in 1967

The City Council then introduced a new bill to address the same situation on September 12, 1967 (Int. No. 474). This bill was largely similar to the version that was passed and signed by Mayor Lindsay as Local Law 120 (which became Section 12-126). *See id.* at 11-12. The bill was marked up in committee and certain language was dropped while other language was added. Among other things, the committee deleted language in the definition of "health insurance coverage," which would have stated that "no . . . insurance contract shall be entered into by the [City] which would reduce . . . benefits as is provided to city employees, city retirees, and their dependents by the [City] as of the effective date of this section." *See id.* at 17. The committee also inserted monetary caps on the City's mandatory contribution to the Medicare premium and to the premium paid for other insurance plans, the latter of which was tied one of the City's health insurance options (H.I.P.-Blue-Cross (21 day) plan). *Id.* Following these changes, the committee recommended adoption on November 21, 1967. *Id.* at 9. The City Council approved the bill on December 5, 1967 and the Mayor approved the bill on December 18, 1967.

5. This Legislative History Does Not Support Any Obligation to Fund "the Entire Cost" of Multiple Healthcare Plans

As is evident from this history, the chief purpose of Section 12-126 was to adjust the *percentage* of premiums paid by the City, *not* to cover such costs for "*any* basic health insurance plan." *Id.* at 6. Petitioners would have the Court read such an obligation into Section 12-126, but Mayor Lindsay squarely rejected that proposal.

Petitioners' other references to the legislative history are just as unavailing. They suggest that Section 12-126 was linked to the City's 1965 decision to offer multiple different health plans (NYSCEF No. 189 at 12-13), but those decisions were quite independent of one another. The City's expansion of its health care offerings in Cal No. 155 was made by the Board of Estimate some *two years prior* to the City Council's enactment of Section 12-126, and before Medicare existed. Section 12-126 was enacted not to affect the *number* of premium-free health insurance plans available, but as a reaction to the City's removal of coverage that was duplicated by Medicare in 1966—coverage retirees were then required to pay for as part of Medicare premiums the City was not covering.

The situation that prompted the adoption of Section 12-126 is a far cry from what is at issue in this case. The City is not proposing to remove benefits from *all of its plans* and then require the retirees to pick up the tab to get that coverage back. As the City and MLC have already pointed out, *see* NYSCEF No. 61, ¶¶ 30-33 and NYSCEF No. 201 at 3, the coverage provided by the MAP is similar to if not better than the currently offered plans, and is being offered with no premium to the retirees. Nothing in that violates Section 12-126.

C. The City's Past Practice Support the City's Interpretation of Section 12-126

The City's past practice also confirms that Section 12-126 does not require the City to offer all health insurance plans premium-free, or without other additional costs. For years, the City has offered many more than the three health insurance options available when Section 12-126 was adopted. *See, e.g., Retiree Health Plan Rates as of January 1, 2022*, N.Y.C. Office of Labor Relations (Dec. 31, 2021), https://www1.nyc.gov/assets/olr/downloads/pdf/health/revised-retiree-rates-jan-2022.pdf (listing 13 non-Medicare and 12 Medicare retiree health insurance options in 2022). These insurance plans have offered retirees a mix of premium-free and premium plans with the majority of plans requiring premiums for the basic plan. *See, e.g., id.* (listing 7 non-Medicare

and 5 Medicare options with premiums for the basic plan). Even those plans that have offered premium-free basic coverage have almost always required premiums for prescription drug coverage or for expanded benefits (such as a 365 day hospital rider for the GHI Senior Care plan, which is included without additional cost in the MAP). *See, e.g., id.* (listing 5 premium-free non-Medicare and 6 premium-free Medicare options as having prescription drug benefit premiums). The status quo, in other words, has long been a mixed bag.

The City has now decided to adjust which retiree options are premium-free and which ones cost a monthly premium, but this presents the same situation retirees have faced every year—a mix of premium-free and premium options. The fact that the City has adjusted the premium costs to retirees *between* plans does not implicate Section 12-126 so long as the City covers "the entire cost" of "health insurance coverage." (Which it does – *see* Sections II.A-B *supra*.) And if offering retirees *any* insurance plan with monthly premiums violated Section 12-126, then the City's entire array of retiree insurance offerings would be called into question, which would be an absurd and disfavored reading. *See McCurdy*, 36 N.Y.3d at 262-263.

III. Section 12-126 Does Not Impact the City's Decisions Regarding Co-Pays and Deductibles

Petitioners no longer appear to be pressing the argument that Section 12-126 precludes the City from charging co-pays and/or deductibles in the MAP, Senior Care, or other offerings. That may be because Section 12-126 does not limit the City's discretion in those areas.

Section 12-126 does not define "entire cost," but as indicated above, the legislative history is rife with the interchangeable use of "cost" and "premium," indicating that Section 12-126 is concerned only with the premiums paid by City employees and/or retirees. The only judge to consider the issue – Judge John Koeltl of the U.S. District Court for the Southern District of New York – surveyed the same legislative history discussed above and found that Section 12-126

"contemplate[s] only premiums," and that the City's obligation to pay the "entire cost of health insurance coverage does not require the City to offer only health insurance plans that impose no copayments and deductibles." *New York 10-13 Ass'n v. City of New York*, No. 98 Civ. 1425 (JGK), 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (internal quotation marks omitted).

In determining that Section 12-126 does not impose a requirement that insurance plans be copay- and deductible-free, Judge Koeltl was further persuaded by the language capping the City's contributions based on the H.I.P.-H.M.O. plan. Thus, including copayments or deductibles in the "cost" the City must cover "would prevent the ready application of the statutory yardstick which only requires the City to pay the cost of insurance of the H.I.P.-H.M.O. plan," meaning that "[t]here would be no reasonable way to compare deductibles and copayments to the straight premium cost of the H.I.P.-H.M.O. plan." *Id.*

Thus, to the extent Petitioners are claiming that Section 12-126 prohibits the City from implementing the MAP because it (or Senior Care) contains co-pays and/or deductibles, that interpretation of Section 12-126 finds no support in the legislative history or text.

CONCLUSION

The Alliance respectfully submits that Section 12-126's plain language and legislative history, and the City's past practice, confirm that the City's choices do not violate Section 12-126. Neither do any of the City's choices as to deductibles, co-pays, or other non-premium aspects of its health insurance offerings. For those reasons, those offered in Respondents' moving papers, and those offered by the MLC in its papers, dismissal of this Article 78 proceeding is appropriate.

February 15, 2022

Respectfully submitted,

/s/ Michael E. DeLarco

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WORD COUNT CERTIFICATION

Pursuant to 22 N.Y.C.R.R. § 202.8-b, the undersigned hereby certifies that this memorandum of law complies with the word count limitation in that rule:

1. Exclusive of the exempted portions, the memorandum of law contains 4,294 words.
2. As permitted, the undersigned has relied upon the word count feature of a word processing system in preparing this certificate.

New York, New York
February 15, 2022

By: /s/ Michael E. DeLarco
Michael E. DeLarco