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

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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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Hon. Lyle E. Frank

Index No. 158815/2021

Mot. Seq. No. 2

BRIEF *AMICUS CURIAE* OF THE NYC MUNICIPAL LABOR COMMITTEE IN <u>SUPPORT OF RESPONDENTS' CROSS-MOTION TO DISMISS</u>

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Pursuant to the Court's oral order at the February 7, 2022 status conference, the NYC Municipal Labor Committee ("MLC") respectfully submits this brief as *amicus curiae* in support of the City of New York's (the "City" or "Respondents") Cross-Motion to Dismiss the Amended Petition ("Motion," NYSCEF No. 95).

PRELIMINARY STATEMENT

For decades, the MLC and the City have negotiated jointly-administered citywide health benefits for hundreds of thousands of active and retired City workers. Recognizing that we are all retirees in training, labor leaders have consistently and carefully negotiated for comprehensive health plans to address retirees' health needs. To that end, the City and MLC have historically worked closely together during various procurements to select multiple health benefits providers and alter plan designs in an effort to protect City employee health benefits. The bargaining process has therefore ensured that retirees' health benefits cannot be changed without offering an adequate equivalent plan.

Petitioners now seek to unravel a carefully negotiated agreement between the MLC and the City that addresses the rising cost of retiree health benefits through a Medicare Advantage Plan ("MAP"), a benchmark plan for retirees. First, Petitioners proceed under the fundamental misunderstanding that Administrative Code § 12-126 ("Section 12-126") requires the City to pay for any available health insurance plan that retirees select below the statutory cap. In doing so, Petitioners incorrectly compare the cost of the existing Senior Care plan to the rate for an inapplicable active employee plan. A plain reading of that code provision and its lengthy legislative history disprove Petitioners' strained reading of the statute. Absent from Section 12-126 is any mention of a requisite number of health plans that the City must offer and Petitioners' efforts to read into the statute a requirement for the City to offer "any and every health insurance plan available" are unsupported. Second, Petitioners' argument that past practice binds the City

to pay for retirees' choice of health plans entirely disregards the historic bargaining process between the City and MLC that led to broader health coverage options for retirees today. Finally, Petitioners' blanket assertion that the MLC does not represent retirees is belied by the 70-year record in which the MLC and the City have negotiated the administration of health plans on behalf of actives and retirees. That process should not be disturbed now.

MLC recognizes the stress caused by changing health coverage, particularly during a pandemic. But that is not a legally justifiable reason to upend a delicately and well-thought out agreement taken to address the soaring costs of healthcare in the City. That benefits or plans have changed does not mean that they have been diminished; rather, the MLC has targeted changes through MAP that enhance efficiencies and improve benefits. A close reading of Section 12-126, the parties' bargaining agreements, and summary plan descriptions all demonstrates that the actions taken were lawful and anything but arbitrary and capricious. Therefore, Petitioners' Article 78 Petition should be dismissed.

BACKGROUND

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

The MLC is an association of New York City municipal labor organizations comprised of some 102 bargaining units representing approximately 390,000 active City workers, their dependents and a community of some 250,000 retirees 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 in Support of Motion to Intervene and in Opposition to the Verified First Amended Petition, "Nespoli Aff.," NYSCEF No. 61, ¶ 2. The MLC is organized pursuant to §§ 12-303 and 12-313 of the Administrative Code of the City of New York and is an association created pursuant to a Memorandum of Understanding dated March 31, 1966, signed by representatives of the City of

New York and certain employee organizations. See id. ¶ 3. The public employees represented by the MLC serve the public welfare, health and safety on a daily basis. See id.

Over the past half century, one of the MLC's central roles has been to negotiate and jointly administer with the 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 the City of New York (or participating agencies) absent collective bargaining with the MLC. See id. (citing N.Y. Civil Service Law §§200, et seq. (the "Taylor Law"); New York City Administrative Code ("Admin. Code") §§12-301, *et seq*. (the "New York City Collective Bargaining Law")). See id. Accordingly, the 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. The City And MLC's Longstanding Bargaining Over Citywide Benefits

The City and the MLC have negotiated regarding the provision of health benefits to the City's retirees since the late 1960s. See id. ¶ 8. Since that time, the City has offered a premium-free option to actives and to retirees: the benchmark plans. See id.¶ 9. Any changes to the benchmark plans must be accomplished through collective bargaining and a jointly-administered process. See id. ¶ 9.

On July 10, 1992, MLC and the City entered into an "Agreement Relating to Procurement of Employee Health Benefits Contracts" (the "1992 Agreement") which memorialized their respective responsibilities relative to the administration of health benefits. See id. ¶ 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). Pursuant to the 1992 Agreement, the MLC and the City jointly prepared several procurements and selected multiple health benefits providers. Id. ¶ 17. Whether the MLC constituent unions vote to accept a proposed procurement is a necessary factor in the procurement process. See id. ¶ 18.

As this Court is aware, this dispute concerns a series of agreements entered into by the MLC and the City concerning Citywide health benefits, specifically the MLC's and City's adoption of MAP for retirees. See id. ¶¶ 19-20. While prior changes to City benefits primarily focused on plans available to active employees,[1] the Tripartite Health Insurance Policy Committee committed to evaluating 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, the MLC leaders overwhelmingly voted to adopt the Alliance program to implement and administer the MAP health insurance plan for the City's retirees. See id. ¶ 29.

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[1] 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 Nespoli Aff. ¶ 14, Ex. 1 (Excerpt of 2004 Plan Booklet at page 132). These increases are in addition to the deductible charged by Medicare, which adjust (generally upward) each year.

The MLC has always endeavored to protect retirees. See id. ¶ 13. For that reason, the MLC opted to first make changes and find efficiencies within the active employee plans before looking to the retiree plans. See id. That protectiveness, however, is not a guarantee that plan designs or vendors will never change. See id. Indeed, the entire Citywide health benefits plan is subject to discussion and, where deemed appropriate, through collective bargaining, change. See id.

ARGUMENT

Petitioners' arguments that the Administrative Code, collective bargaining agreements, summary plan descriptions and the Constitution allow them to undo the City's and MLC's carefully negotiated health plan, lacks merit. None of those documents guarantees that a specific health program will be offered in perpetuity without any adjustment.

1. The Plain Meaning of Administrative Code § 12-126 Does Not Require The City To Offer A Specific Health Plan In Perpetuity

Petitioners' central argument rests on the fundamentally flawed premise that Section 12-126 of the Administrative Code requires the City to pay for any available health insurance plan up to an incorrectly identified specified dollar cap. See Petitioners' Memorandum of Law in Support of Their Motion for Summary Judgment, "Petitioners' MOL," NYSCEF No. 189 at 4. Section 12-126 provides that: "[t]he 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.C. Admin. Code § 12-126(b)(i).

Petitioners' reliance on the definition of "health insurance coverage" to argue that it encompasses multiple plans is baseless. See Petitioners' MOL at 9. Petitioners cite to an excerpted definition of "health insurance coverage" in support of that argument, defining it as "hospital-surgical medical benefits to be provided by health and hospitalization insurance

contracts entered between the city and companies providing such health and hospitalization insurance." See Petitioners' MOL at 10-11 (citing N.Y.C. Admin. Code § 12-126(a)(iv)). What Petitioners studiously avoid quoting, however, is the beginning of the definition providing that "health insurance coverage" is a singular ***program*** of "hospital-surgical medical benefits." Id. at 9-10 That the definition of "health insurance coverage" references multiple "companies" or "contracts" does not change the fact that "health insurance coverage" can be limited to one plan. Indeed, GHI-CBP and Senior Care—the two most popular plans for actives and retirees[2] —are provided by a combination of companies and contracts, even though they are each one plan.

Moreover, the Administrative Code discusses "health insurance coverage" interchangeably with "health insurance plan." Section 12-126(b)(2) discusses "health insurance coverage" for specific individuals like "surviving spouses, domestic partners and children of certain city employees." N.Y.C. Admin. Code § 12-126(b)(2). That section provides that the surviving spouse of a retired member of the fire department, police department, or department of correction or sanitation who was enrolled "in a specific ***health insurance plan***" will be "afforded the right to such ***health insurance coverage***." See id. § 12-126(b)(2)(ii), (iii), (iv). That "health insurance coverage" is "predicated on the insured's enrollment in ***the*** hospital and medical program for the aged and disabled under the social security act." See id. These statutory provisions confirm that "health insurance coverage" can be interpreted as limited to one plan.

Section 12-126's silence as to the requisite number of health plans that the City must offer is also dispositive. The failure of the legislature to include a matter within the scope of the act indicates that its exclusion was intended, and the Court should decline to legislate on the matter. See N.Y. Stat. Laws § 74 (McKinney) (Construction and Interpretation) ("the failure of

[2] MLC notes that these are not the only plans offered to actives and retirees.

the Legislature to include a matter within the scope of an act may be construed as an indication that its exclusion was intended"); see also New York City Campaign Fin. Bd. v. Ortiz, 38 A.D.3d 75, 83 (1st Dep't 2006) ("This Court cannot by implication supply in § 3–710(2)(b) a provision that, we might reasonably suppose, the City Council intended to omit."); Matter of Lyles, 250 A.D.2d 488, 490 (1st Dep't 1998) ("The legislative silence was thus intentional . . . and does not create a vacuum inviting judicial creativity."). Accordingly, Petitioners' attempt to read into the statute a requirement that the City must offer "multiple health insurance plans" or "any" health insurance plan is plainly at odds with the statutory language. See Petitioners' MOL at 9. Indeed, it is through collective bargaining and the work of the MLC/City healthcare committee, not statutory mandate, that a variety of plans to serve different needs have become part of the City's offering over time.

2. Administrative Code § 12-126's Legislative History Confirms That The City Is Not Required To Provide Multiple Insurance Plan Options to Retirees

Section 12-126's legislative history demonstrates that the statute was intended to authorize the City to contract with various entities, but the specific plan offerings would be determined by the City and MLC through the collective bargaining process. Petitioners' self-serving discussion of Section 12-126's legislative history is entirely imprecise. More than seventy years ago, on October 24, 1946, under Calendar No. 11 of the Board of Estimate, a report was submitted, at the request of the Mayor, regarding proposals to provide health insurance to City employees. See Affirmation of Steven Cohen, "Cohen Aff.," NYSCEF No. 186, Ex. C at 23, 56 NYSCEF No. 192 Following careful analysis of the respective benefits, costs, and services of each proposal, the Board of Estimate designated HIP exclusively as the provider of such insurance with the City paying "up to 50 per cent of the premiums." See id.

Over the next twenty years, the City continued to look to HIP for provision of healthcare to City employees. In 1965, at the request of the Uniformed Forces and as the result of collective bargaining between the City and MLC, the City expanded providers to include for-profit groups. See Cohen Aff., Ex. C at 24, ("Whereas, As a result of collective bargaining engaged in between the City and the duly chosen majority representatives of certain other classes of employees, agreements were reached and Personnel Orders issued by the Mayor extending to various additional classes of employees the aforestated choice of hospital-surgical-medical plans on terms and conditions set forth in such Personnel Orders"); 25-30 (same). On February 11, 1965, the Board of Estimates approved under Calendar No. 155 HIP as the Base Plan with the City paying 75% of the cost of the HIP-Blue Cross Base Plan for insurance for one year and 100% thereafter of the full cost of HIP-Blue Cross Base Plan. See id. at 24, 36.

On December 5, 1967, the City Council approved Local Law 120, designating HIP as the base plan provider against which the 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 the City. See id. at 20. The final text excluded language regarding a "basic health insurance plan" because it was not sufficiently defined in the bill and would require the City to "be bound" by "an open-ended obligation to pay for coverages which it cannot now possibly anticipate." See id. at 8.

In 1985, the City Council passed a new bill (Intro # 744-A), which resulted in Section 12-126 in its present form. Section 12-126 provided that HIP (through its HIP-HMO product) would be the Base Plan and the 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. In addition to Section 12-126, the City and MLC entered into collective bargaining agreements designating HIP as the Base Plan with the 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.

Against this backdrop, Petitioners' reliance on a 1967 session stating that Local Law 120 "would provide that the City of New York pay for the entire cost of ***any*** health insurance plan" does not evidence an obligation for the City to fund the cost of multiple health plans. See Petitioners' MOL at 9-10; Cohen Aff., Ex. C at 6, 9. Setting aside the substantive misrepresentations in Petitioners' briefing about Section 12-126's legislative history, Merriam-Webster's Dictionary defines "any" as "***one*** or more" and is "used to indicate an ***undetermined number or amount.***" See Merriam-Webster, "any," available at https://www.merriam-webster.com/dictionary/any (last accessed Feb. 13, 2022) (emphasis added). Thus, Petitioners' own selective excerpt from the legislative history confirms that the City could satisfy its financial obligation under the Code by providing one plan.

That the City offered multiple health insurance plans since 1965, two years before Local Law 120's enactment, is not dispositive. See Petitioners' MOL at 12. Even with the expansion of multiple health plans in the 1965 bill, impacted stakeholders submitted memoranda confirming that: (i) there was no requirement for the City to offer more than one plan under the proposed legislation and (2) the City was afforded immense discretion in choosing an insurer and administering the plan. A May 25, 1965 memo from the New York State Department of Social Welfare described the purpose of the bill as enabling the City "to contract for and administer **a**

health insurance plan for active and retired employees." Cohen Aff., Ex. C at 69 (emphasis added). A memorandum from the City from that same month shows that the amendment was intended to "offer a wider choice of health insurance plans" (including for-profit insurers) with the City assuming "all or **part of the cost of such plans as may be deemed proper.**" Id. at 62 (emphasis added). A June 4, 1965 Report to the Governor from the State Comptroller is also illuminating. See id. at 65. It indicates that "the bill will facilitate the contracting **for a health insurance plan, and the administration thereof, by New York City. . . .**" Id. at 65 (emphasis added). That same month, the City Bar of New York wrote that the bill would allow the City to "enter into contracts with **one or more insurance companies** for the purpose of furnishing medical, surgical and hospital service" for City employees. See id. at 81 (emphasis added). A July 14, 1965 memo from the Office of Local Government understood the purpose of the bill to "empower the City to assume all or **part of the cost of health insurance, with the balance, if any, to be paid by the employees.**" Id. at 72 (emphasis added). Finally, a memo from the State Department of Civil Service stated that the amendment would allow the City "to contract for health insurance coverage for its active and retired officers and employees." Id. at 67. "[S]uch contracts by the [City] **could be made with one or more insurance companies authorized to do business in this State.**" Id. (emphasis added). As a result of collective bargaining, on December 16, 1965, the Board of Estimate extended the undertaking to pay 100% of the coverage costs over the "Base Plan" to all City employees under Calendar No. 292. See id. at 24. The Mayor's memorandum in support of the bill is consistent with these interpretations. He said that "[t]he primary thrust of this bill is to enable the [City] to institute **a choice of health insurance plan** identical in formal outline to that in operation for State employees. This type of

plan has been negotiated in collective bargaining [with other unions]." Id. at 77 (emphasis added).

The adoption of Local Law 120 did not alter the City's obligation to provide one plan on a premium-free basis. See Petitioners' MOL at 12. Indeed, Petitioners ask this Court to interpret the statute in a manner that was specifically rejected by the City Council in 1967 when it excluded language from Local Law 120 requiring the City to fund "the entire cost of any basic health insurance plan." Mayor Lindsay reasoned that this provision "would be bound by an open-ended obligation to pay for coverages which it cannot possibly anticipate." See Cohen Aff., Ex. C at 6-8. Requiring the City to indefinitely pay for multiple health plans is therefore directly at odds with the statute's legislative purpose.

Finally, Petitioners' unsupported assertion that only allowing for one premium-free option under the statute results in the City funding a plan with worthless benefits is an affront to the bargaining process. See Petitioners' MOL at 11 n. 6. Respondents' interpretation of Section 12-126 does not give the City *carte blanche* to implement an unfavorable plan. Instead, the legislative history since 1965 confirms that the bargaining process gives the MLC and City an avenue to provide enhanced health plans. At a time when HIP was too restrictive because it only provided one non-profit option, MLC pushed to expand the City's health plan offerings (including with Medicare Part B coverage). Using bargaining to protect retirees' health coverage is playing out the same way now. In an effort to address skyrocketing healthcare costs, the City and MLC agreed to MAP (as well as free plans like HIP VIP and Aetna) as a cost-effective way to provide the same or better benefits to retirees than current plans. 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 the City and the MLC therefore continue to ensure solid health plans for all City workers.

3. Petitioners Incorrectly Compare The Cost of Existing Senior Care To The Rate Of An Inapplicable Active Plan

Petitioners' motion for summary judgment also rests on the unsupported proposition that the City must pay up to a "statutory cap" of $776, or the cost of the HIP-HMO plan. See Petitioners' MOL at 7 n. 2 (citing Cohen Aff. Ex. B). The $776 figure represents the 2021 monthly cost of an *active* plan—*i.e.*, a "Non-Medicare Single" HIP-HMO plan. See Cohen Aff., Ex. B at 127. It has long been understood that the HIP active rate is not an appropriate reference for consideration of any obligation to provide plans for Medicare-eligible retirees. Rather, the City and the MLC have through collective bargaining agreed over the years upon a "pay-up" cost that would establish a standard or "benchmark" amount up to which the City would contribute to the cost of retiree plans that it offered.

As has previously been pointed out, there are pre-65 retirees and Medicare-eligible retirees participating in City health plans. For pre-65 retirees who participate in the active plans, the 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-65 retirees. However, once a retiree becomes eligible for Medicare, they fall into a different category. Medicare becomes primary, with the City reimbursing the cost of Medicare Part B such that basic Medicare coverage is likewise premium free. Senior Care is a medigap supplemental plan and therefore *not of the same category* as the HIP-HMO plan referenced by Petitioners. The MLC and the City have historically, through collective bargaining, set the baseline, premium-free plan for Medicare-eligible retirees. In doing so, they have provided a plan that is more robust than, for example, the HIP VIP Premier (HMO) plan that is one of several options besides Senior Care

available to retirees. The new MAP plan tracks Senior Care and is also more robust than the HIP VIP plan and some others.

The "pay-up" cost of other plans available to retirees has been determined in relation to the baseline plan. Take the range of health plans offered by the 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 Feb. 14, 2022). The City currently offers twelve Monthly Medicare health plans for individuals and families. See id. 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 Petitioners' stated $766 benchmark rate. Senior Care will now simply be another of these plans that is offered as an alternative to the premium-free MAP plan, which meets the 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, the City continues to comply with the Administrative Code and its collective bargaining obligations.

4. The City's Past Practice Does Not Evidence An Obligation To Fund The "Entire Cost" Of Multiple Healthcare Plans

Petitioners incorrectly assert that the City's practice of paying for certain health insurance options that cost below what they identify as the statutory cap is a "tacit and binding concession" that Section 12-126 requires the City to continue to pay for these plans. See Petitioners' MOL at 13. That argument entirely ignores the bargaining process whereby the City and MLC have negotiated changes and modifications to healthcare benefits for years. Nothing in Section 12-126, or the CBAs suggest that Petitioners' healthcare benefits would be set in stone in perpetuity.

In that regard, the CBAs between the 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 the 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 the City and MLC also contemplate changes to Citywide health benefits. See, e.g., The City University of New York Agreement between The City University of New York and the Professional Staff Congress/CUNY, Verified First Amended Petition Ex. C at 160 (NYSCEF Doc. 32) (noting that the agreement can be modified by the parties in writing); 1995 Municipal Coalition Memorandum of Economic Agreement, Verified First Amended Petition Ex. F at 13 (NYSCEF Doc. 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, Verified First Amended Petition Ex. G at 23 (NYSCEF Doc. 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, Verified First Amended Petition Ex. M. at 7 (NYSCEF Doc. 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, Verified First

Amended Petition Ex. H at 12 (NYSCEF Doc. 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 the City and MLC have historically used the bargaining process to modify retirees' health benefits, just like they did here. That Petitioners are unhappy with the result in this instance does not warrant unwinding decades of past practice leading to the MAP option.[3]

Petitioners' 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. Civil Service Law § 209-a. As long as the City and MLC are bargaining over health benefits, Petitioners do not have a right to interfere with that process and claim an unchangeable right to a health plan of their choosing.

5. Petitioners' Remaining Claims Fail

Petitioners' remaining claim that the Moratorium Statute prevents the City from implementing the MAP plan because it forces retirees to accept inferior benefits from actives is against the weight of the evidence. See Petitioners' MOL at 26. In addition to the City's arguments, see Motion at 6-7 and Reply 14-16, the Moratorium Law does not create a *per se* bar against reducing retiree health benefits. Rather, the statute focuses on whether changes to retiree benefits during the active period (April 1, 2012 through 2021) were disproportionate in

[3] For similar reasons, Petitioners' arguments that the MLC does not represent them is of no moment. See Petitioners' MOL at 20-21. The issue here is not a question of whether the MLC broadly represents Petitioners, who recently stepped into this process, but whether the history, documents, and negotiating relationship between the City and MLC evidences an intent that Citywide healthcare benefits can be modified through bargaining going forward. The record plainly shows that it can.

comparison to changes made to active employee benefits. The evidence shows that changes to Citywide health benefits during the relevant time period have primarily been to the active health plans. See Nespoli Aff., ¶ 21. Examples of some collectively bargained changes made to active benefits under the recent agreements include:

- Effective 7/1/2016
    - CBP Plan: (1) Limited Preferred Provider copay reduced to $0 and copay for all other specialist providers increased to $30, (2) Urgent Care copay increased to $50; (3) Emergency Room copay increased to $150; (4) Increased out of pocket maximus for CY 2017 to $4,550/ $9,100 for single/family for GHI & $2,600 / $5,200 for single/family for Empire;
    - HIP HMO: Preferred provider network introduced creating split in copays of $0 for preferred providers and $10 for non-preferred
- Effective 7/1/2017
    - HIP HMO: (1) urgent care copay increased to $25 and (2) emergency room copay increased to $150

See Nespoli Aff. ¶ 21. Thus, the time period covered by the Moratorium Statute is broad and, indeed, there have been far more changes to active health benefits than retiree benefits during that period.

Finally, the MLC understands that changing health benefits can cause anxiety and uncertainty for some, but disagreement with the MAP plan is not a legitimate basis to undo a carefully orchestrated process negotiated by the City and MLC. See Petitioners' MOL at 5. MLC and Alliance conducted extensive outreach campaigns to educate retirees about MAP. See Nespoli Aff. ¶ 35. That outreach shows that retirees generally have a positive view of MAP and

the Alliance. See id. Importantly, evidence submitted in this case shows that the MAP plan does not present a reduction in benefits; rather, it provides the "same comprehensive coverage in the context of the Medicare Advantage Structure and adds certain additional benefits not available under Senior Care." See Affidavit of Geofrey Sorkin, "Sorkin Aff.," NYSCEF No. 76, ¶ 7. MAP will provide significant savings to the City because of the federal subsidy for Medicare Advantage products. See Sorkin Aff. ¶ 12. Savings that can be accomplished without diminution in benefits is critical to addressing skyrocketing prices in healthcare for active and retiree communities. See id. Denying Respondents' Motion would therefore cause tremendous hardship to the 250,000 other retirees that the MLC represents. See Nespoli Aff. ¶ 34.

CONCLUSION

For the reasons set forth above and in Respondents' Motion and Reply, the MLC respectfully submits that dismissal of this Article 78 proceeding is appropriate.

Dated: New York, New York
February 15, 2022

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WORD COUNT CERTIFICATE

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Date: February 15, 2022

/s/ Alan M. Klinger