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

ROBERT BENTKOWSKI, KAREN ENGEL, MICHELLE FEINMAN, NANCY LOSINNO, JOHN MIHOVICS, KAREN MILLER, ERICA RHINE, ELLEN RIESER, and BEVERLY ZIMMERMAN, on behalf of themselves and all others similarly situated, and THE NEW YORK CITY ORGANIZATION OF PUBLIC SERVICE RETIREES, INC.,

Petitioners-Plaintiffs,

v.

THE CITY OF NEW YORK; ERIC ADAMS, Mayor of the City of New York; THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS; RENEE CAMPION, Commissioner of the Office of Labor Relations; THE NEW YORK CITY DEPARTMENT OF EDUCATION (a/k/a THE BOARD OF EDUCATION OF THE CITY SCHOOL DISTRICT OF THE CITY OF NEW YORK); and DAVID C. BANKS, Chancellor of the New York City Department of Education,

Respondents-Defendants.

Index No.:

ORAL ARGUMENT REQUESTED

MEMORANDUM OF LAW IN SUPPORT OF PETITIONERS-PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

WALDEN MACHT & HARAN LLP
250 Vesey Street, 27th Floor
New York, NY 10281

POLLOCK COHEN LLP
60 Broad St., 24th Floor
New York, NY 10004

Counsel for Petitioners-Plaintiffs

TABLE OF CONTENTS

Pages

PRELIMINARY STATEMENT 1

STATEMENT OF FACTS 5

A. Medicare and Medicare Supplemental Insurance 5

B. Medicare Advantage 8

C. The City's Initial Attempt to Force Retirees into Medicare Advantage was Declared Unlawful 14

D. The City's New Scheme to Force Retirees into Medicare Advantage 15

ARGUMENT 21

I. PETITIONERS ARE LIKELY TO SUCCEED ON THE MERITS 21

A. Promissory Estoppel 22

B. Life-Threatening Disruption of Care 36

C. Moratorium Law 39

D. City Administrative Procedure Act 47

E. Missing and Inaccurate Information 53

II. RETIREES WILL SUFFER IRREPARABLE HARM ABSENT A PRELIMINARY INJUNCTION 57

A. Enrolling in the Aetna MAP will Cause Irreparable Harm 57

B. Opting out of the Aetna MAP will Cause Irreparable Harm 63

C. Retirees will Suffer Additional Irreparable Harm Regardless of their Enrollment Decision 64

III. THE BALANCE OF EQUITIES WEIGHS HEAVILY IN THE RETIREES' FAVOR 67

CONCLUSION 69

TABLE OF AUTHORITIES

Pages

Cases

1700 York Assocs. v. Kaskel,
182 Misc. 2d 586 (Civ. Ct. N.Y. Cty. 1999)........ 49, 50

Abbruscato v. Empire Blue Cross and Blue Shield,
274 F.3d 90 (2d Cir. 2001)........ 36

Aetna Life Insurance Company v. Renee Campion et al.,
Index No. 158216/2021 (Sup. Ct. N.Y. Cty.)........ 3, 46

Agress v. Clarkstown Cent. Sch. Dist.,
69 A.D.3d 769 (2d Dep't 2010)........ 23, 35

Alaska v. Lubchenco,
2012 WL 13035040 (D. Alaska), *aff'd*, 723 F.3d 1043 (9th Cir. 2013)........ 65

Allen v. Bd. of Educ. of Union Free Sch. Dist. No. 20,
168 A.D.2d 403 (2d Dep't 1990)........ 31, 35

Anderson v. Niagara Falls City School District,
125 A.D.3d 1407 (4th Dep't 2015)........ 42, 43

Angotti v. Rexam, Inc.,
2006 WL 1646135 (N.D. Cal. June 14, 2006)........ 62, 66

Ass'n of Messenger Servs., Inc. v. City of New York,
136 Misc. 2d 869 (Sup. Ct. N.Y. Cty. 1987)........ 49

Barbes Rest. Inc. v. ASRR Suzer 218, LLC,
140 A.D.3d 430 (1st Dep't 2016)........ 21

Bass v. WV Pres. Partners, LLC,
209 A.D.3d 480 (1st Dep't 2022)........ 59

Becker v. Toia,
439 F. Supp. 324 (S.D.N.Y. 1977)........ 62, 68

Bianculli v. City of New York Office of Labor Relations,
2023 WL 3633367 (1st Dep't May 25, 2023)........ 42, 63

Bianculli v. City of New York Office of Labor Relations,
No. 160234/2022, 2023 WL 158773 (N.Y. Sup. Ct. Jan. 11, 2023)........ 42, 63, 68

Branca v. Bd. of Educ., Sachem Cent. Sch. Dist. at Holbrook,
239 A.D.2d 494 (2d Dep't 1997) 36

Bryant v. Bd. Of Edu.,
21 A.D.3d 1134 (3d Dep't 2005) 40

Callahan v. Carey,
2012 WL 680318 (Sup. Ct. N.Y. Cty. Feb. 21, 2012) 49

Castellotti v. Free,
138 A.D.3d 198, (1st Dep't 2016) 23

Cicio v. Does,
321 F.3d 83 (2d Cir. 2003) 10

Civ. Serv. Emps. Ass'n, Inc., Loc. 1000, AFSCME, AFL-CIO v. New York State (Unified Ct. Sys.),
73 Misc. 3d 874 (Sup. Ct. Albany Cty. 2021) 61

Cole v. Mandell Food Stores, Inc.,
93 N.Y.2d 34 (1999) 49

Commc'ns Workers of Am., Dist. One, AFL-CIO v. NYNEX Corp.,
898 F.2d 887 (2d Cir. 1990) 64

Consumer Directed Pers. Assistance Ass'n of New York State v. Zucker,
65 Misc. 3d 1005 (Sup. Ct. Albany Cty. 2019) 52

Council of City of New York v. Dep't of Homeless Servs. of City of New York,
22 N.Y.3d 150 (2013) 51

Ferlazzo v. 18th Ave. Hardware, Inc.,
33 Misc. 3d 42 (Sup. Ct. Bronx Cty. 2011) 8

Freeport Police Benev. Ass'n v. The Incorporated Village of Freeport,
2012 WL 1642709 (Sup. Ct. Nassau Cty. Apr. 20, 2012) 58

Golden v. Kelsey-Hayes Co.,
845 F. Supp. 410 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996) 62

HD Servs., LLC v. New York State Comptroller,
51 A.D.3d 1236 (3d Dep't 2008) 51

Int'l Union of Operating Engineers, Loc. No. 463 v. City of Niagara Falls,
191 Misc. 2d 375 (Sup. Ct. Niagara Cty.), *aff'd*, 298 A.D.2d 1010 (4th Dep't 2002) 58

Jones v. Bd. of Educ. of Watertown City Sch. Dist.,
6 Misc.3d 1035(A) (Sup. Ct. Jefferson Cty. 2005), *aff'd*, 30 A.D.3d 967 (4th Dep't 2006) 40, 42

Kahrmann v. Crime Victims Bd.,
14 Misc. 3d 545 (Sup. Ct. Albany Cty. 2006) 51

LaForest v. Former Clean Air Holding Co.,
376 F.3d 48 (2d Cir. 2004).......... 62, 66

Louisiana v. Horseracing Integrity & Safety Auth. Inc.,
2022 WL 2960031 (W.D. La.).......... 65

Mamula v. Satralloy, Inc.,
578 F. Supp. 563 (S.D. Ohio 1983) 60

Matter of Baker v. Bd. of Educ.,
29 A.D.3d 574, (2d Dep't 2006) 43

Matter of Sheriff Officers Ass'n, Inc. v. Nassau County,
2012 WL 2367795 (Sup. Ct. Nassau Cty. 2012) 58

Merkner v. AK Steel Corp.,
2010 WL 373998 (S.D. Ohio Jan. 29, 2010) 62, 66

NRP Holdings LLC v. City of Buffalo,
916 F.3d 177 (2d Cir. 2019).......... 23

NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,
210 A.D.3d 559 (1st Dep't 2022) 15, 24, 41

NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,
No. 158815/2021, 2021 WL 4920705 (Sup. Ct. N.Y. Cty. Oct. 21, 2021). 53, 68

NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,
No. 158815/2021, 2022 WL 17078320 (1st Dep't 2022).......... 41

NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,
No. 158815/2021, 2022 WL 624606 (Sup. Ct. N.Y. Cty. Mar. 3, 2022) 15

Olcott v. 308 Owners Corp.,
189 A.D.3d 687 (1st Dep't 2020) 21

Olson v. Wing,
281 F. Supp. 2d 476 (E.D.N.Y.), *aff'd*, 66 F. App'x 275 (2d Cir. 2003) 62

Perrotta v. Syosset Central Sch. Dist.,
210 A.D.3d 986 (2d Dep't 2022).......... 40, 42

Plattsburgh City Retirees' Ass'n v. City of Plattsburgh,
2016 WL 1424371 (Sup. Ct. Clinton Cty. 2016) 58

Plattsburgh City Retirees' Ass'n v. City of Plattsburgh,
51 Misc. 3d 1209(A) (Sup. Ct. Clinton Cty. 2016) 67

Republic of Lebanon v. Sotheby's,
167 A.D.2d 142 (1st Dep't 1990) 22

RiseDelaware Inc. v. DeMatteis,
2022 WL 11121549 (Del. Super. Ct. Oct. 19, 2022) 13, 48, 52, 65

Robinson v. New York,
24 A.D.2d 260 (1st Dep't 1965) 23

Schalk v. Teledyne, Inc.,
751 F. Supp. 1261 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991) 62, 66

Schlosser v. United Presbyterian Home at Syosset, Inc.,
56 A.D.2d 615 (2d Dep't 1977) 22

Schwartfigure v. Hartnett,
83 N.Y.2d 296 (1994) 51, 53

Strouchler v. Shah,
891 F. Supp. 2d 504 (S.D.N.Y. 2012) 60

Suffolk Cty. Ass'n of Mun. Emps., Inc. v. Cty. of Suffolk,
163 A.D.2d 469 (2d Dep't 1990) 59

Texas v. Becerra,
577 F. Supp. 3d 527 (N.D. Tex. 2021) 65

Thrower v. Perales,
138 Misc. 2d 172 (Sup. Ct. N.Y. Cty. 1987) 66, 67

Transp, Inc. v. Bd. of Educ. of New York City,
1996 WL 34573240 (Sup. Ct. N.Y. Cty. Dec. 24, 1996) 51

United Steelworkers of Am., AFL-CIO v. Textron, Inc.,
836 F.2d. 6 (1st Cir. 1987) 62, 66

Vassenelli v. City of Syracuse,
138 A.D.3d 1471 (4th Dep't 2016) 35

Warshaw v. Jacobs,
16 Misc. 2d 844 (Sup. Ct. Queens Cty. 1959) 68

Whelan v. Colgan,
602 F.2d 1060 (2d Cir. 1979).......... 64

Wilson v. Gordon,
822 F.3d 934 (6th Cir. 2016) 60

Zotto v. Scovill, Inc.,
1985 WL 14176 (D. Conn. Nov. 7, 1985) 62

Statutes

42 U.S.C. § 1395w-25.......... 9

42 U.S.C. § 1395w-23.......... 9

L. 1994, Ch. 729, as amended by L. 2009, Ch. 30 and Ch. 501 39

N.Y. Gen. City Law § 20(29-b) 30

N.Y.C. Charter, Ch. 45 (City Admin. Proc. Act), § 1041.......... 48, 50

N.Y.C. Charter, Ch. 45 (City Admin. Proc. Act), § 1043.......... 48

N.Y.C. Admin. Code § 12-126 .... 13, 24, 30

Petitioners-Plaintiffs ("Petitioners"), by their undersigned counsel, respectfully submit this Memorandum of Law in support of their motion for a temporary restraining order and preliminary injunction prohibiting Respondents-Defendants (collectively, "the City") from forcing Medicare-eligible retired City workers and their Medicare-eligible dependents off of their existing health insurance pending a determination on the merits.

PRELIMINARY STATEMENT

Since 1966, every single City worker was promised in writing (and often verbally as well) that if they spent their career serving this City, when they and their dependents became Medicare-eligible (*i.e.*, elderly or disabled), they would be entitled to City-funded healthcare through a combination of Medicare plus Medicare "supplemental" insurance (which covers the portion of healthcare expenses that Medicare does not cover). Up until now, the City has always honored that promise: for the past 57 years, all Medicare-eligible retired City workers and their Medicare-eligible dependents (the "Retirees") have been able to enroll in Medicare plus their choice of City-funded Medicare supplemental plans.

In March 2023, the City announced that, beginning September 1, it would no longer honor this healthcare promise. On that date, absent injunctive relief, the City will strip Retirees of their Medicare-plus-supplemental insurance and automatically enroll them in a very different—and far inferior—type of health insurance called "Medicare Advantage." Specifically, the City will enroll them in a Medicare Advantage plan administered by Aetna (the "Aetna MAP"). Retirees can opt out of the Aetna MAP by June 30, but they will then have to find and pay for health insurance coverage on their own. For thousands of Retirees with uninsurable medical conditions, that will be impossible. For the rest, who are healthy enough to pass medical underwriting or who live in

one of the four states that guarantee access to Medicare supplemental insurance, it will cost several thousand dollars a year, which is prohibitively expensive for these fixed-income Retirees.

When Mayor Adams was running for office, he opposed the idea of forcing Retirees into a Medicare Advantage plan, stating that it would be an unfair "bait and switch" that would "traumatize" these elderly and disabled individuals.[1] He added: "You don't become a civil servant to become a billionaire. You become a civil servant to have stable health care, a stable pension and a stable life, and we cannot destabilize it after they retire. Right now, after serving your city, we should not do any type of bait and switch. When you retire, you retire with an understanding, and we need to make sure we live up to that agreement."[2] After he got elected, however, he abruptly changed his mind. That is because forcing Retirees off of their City-funded health insurance and into the federally funded Aetna MAP will cause hundreds of millions of dollars a year to flow into a discretionary fund controlled by the Mayor and union leaders, who do not represent retirees.[3]

Even Aetna previously opposed the idea of forcing Retirees into a Medicare Advantage plan. In 2021, when the City tried (unsuccessfully) to force Retirees into a different Medicare Advantage plan by charging them a prohibitive amount for their existing health insurance, Aetna (whose bid to administer the plan was rejected) sued the City and decried its "drastic[] reduc[tion]"

---

[1] *See, e.g.,* Michael Gartland, *Eric Adams calls Mayor de Blasio's NYC retiree health care shift a 'bait and switch'*, NEW YORK DAILY NEWS, Oct. 15, 2021, https://perma.cc/GC9T-H2EU.

[2] *Id.*

[3] *See, e.g., Testimony of Jonathan Rosenberg to the New York City Council Committee on Civil Service and Labor Regarding Changes to Municipal Retirees' Healthcare Plan,* October 28, 2021, https://perma.cc/9VHP-U33C, at 1 ("Rosenberg Testimony") (explaining how the switch to Medicare Advantage would "provide[] the city with no actual budgetary savings").

in Retirees' healthcare "choice."[4] Aetna argued that "[i]f the City is not enjoined, . . . the retirees will be irreparably harmed."[5] Now that Aetna will receive hundreds of millions of dollars a year to administer the City's new Medicare Advantage plan, it is apparently happy to facilitate this suffering.

Although cutting costs on the backs of elderly and disabled Retirees may benefit the Mayor, the unions, and Aetna, it will irreparably harm the Retirees. Unlike Retirees' longstanding Medicare-plus-supplemental insurance, the Aetna MAP: (1) will be accepted only by a limited network of doctors, hospitals, and continuing care facilities; (2) will not cover a vast array of medical services unless and until Aetna deems them "medically necessary," which it has strong financial incentives not to do; and (3) will expose Retirees to a variety of new and potentially crippling costs. Accordingly, if Retirees are forced into the Aetna MAP, they will lose access to many of their medical providers; they will be subject to dangerous denials of and delays in care; and they will face increased medical expenses few can afford. The hundreds of Retiree and expert affidavits attached to this motion confirm this.

The City's radical overhaul of Retiree healthcare is not just harmful, it is also unlawful. Although there are a dozen ways in which the City is violating the law (which are detailed in the Petition/Complaint), for the sake of judicial efficiency, we focus here on only five.

First, because the City clearly and unambiguously promised every Retiree that they would be entitled to City-funded Medicare-plus-supplemental insurance when they became Medicare-

---

[4] *Aetna Life Insurance Company v. Renee Campion et al.,* Index No. 158216/2021 (Sup. Ct. N.Y. Cty.) ("Aetna Litigation"), NYSCEF Doc. No. 6 at Ex. 5, p. 5.

[5] *Id*., NYSCEF Doc. No. 16 at 6.

eligible, and because Retirees reasonably relied to their detriment on that promise, the City is estopped from denying them such insurance coverage now.

Second, because the City's new healthcare policy will force Retirees with life-threatening illnesses whose doctors will not accept the Aetna MAP to either switch doctors mid-treatment or proceed without insurance coverage, it is arbitrary, capricious, and an abuse of discretion, in violation of CPLR 7803(3).

Third, because the City will be diminishing the healthcare benefits provided to Retirees and the contributions made to their health insurance without similarly diminishing either the benefits or contributions for active employees, it is violating in two separate ways the Retiree Health Insurance Moratorium Act.

Fourth, because the City has changed the rules governing Retiree healthcare without complying with the procedures required under the City Administrative Procedure Act, its new healthcare policy is invalid.

And fifth, because the City is providing incomplete and inaccurate information about the Aetna MAP, Retirees cannot make an informed opt-out decision by the June 30 deadline.

The City is on the verge of stripping a quarter-million elderly and disabled Retirees of Medicare benefits they were promised and desperately need. Given the extreme suffering this will cause and Petitioners' likelihood of success on the merits, this Court should temporarily enjoin the City's new healthcare policy pending a decision on the merits. The City has provided, and Retirees have relied on, Medicare plus supplemental insurance for the past 57 years. This Court should maintain that critical status quo while this case proceeds.

STATEMENT OF FACTS

A. Medicare and Medicare Supplemental Insurance

Retired New York City firefighters, paramedics, cops, teachers, and other civil servants dedicated their lives to—and in many cases risked their lives for—this City. They did not do so for the money. Most would have made a better living, and enjoyed a safer and healthier existence, in the private sector. They toiled away for years in underappreciated jobs, sacrificing their bank accounts and often their safety, in order to serve their fellow New Yorkers and secure the retirement benefits guaranteed by the City. Chief among those benefits for elderly and disabled Retirees is City-funded healthcare through a combination of Medicare plus Medicare supplemental insurance.

Medicare came into existence in 1966. It is a beloved federal health insurance program for senior citizens (those 65 or older) and younger individuals with certain illnesses or disabilities. It is not free: Medicare Part B, which covers outpatient care, has a monthly premium. And it does not cover approximately 20% of healthcare expenses. In order to encourage people to work for the City despite the low pay, the City has always provided Medicare-eligible retirees and their Medicare-eligible dependents reimbursement for their Medicare Part B premium as well as City-funded Medicare "supplemental" (also known as "Medigap") insurance to fill the 20% gap in Medicare coverage. Pizzitola Affidavit ("Aff.") at ¶¶ 9-11; Barrios-Paoli Aff. at ¶¶ 27-29, 41; Zimmerman Aff. at ¶ 4. Although the City has always offered several Medical supplemental plans, the most popular by far has always been "Senior Care," which is administered by the not-for-profit insurance company EmblemHealth. Pizzitola Aff. at ¶ 13.[6]

---

[6] *See, e.g.*, EmblemHealth, *Why EmblemHealth,* 2023, https://perma.cc/96QM-BCEY.

The City did not just provide and pay for Medicare plus supplemental insurance, it explicitly promised its employees, retirees, and their dependents that it would do so when they became eligible for Medicare. Indeed, as detailed further in Part I.A, *infra*, every single year for the past half-century, the City has repeatedly informed all of its employees and retirees in countless written and verbal communications that when they and their dependents became Medicare-eligible, they would be entitled to City-funded healthcare through a combination of Medicare plus Medicare supplemental insurance. For example, the City's healthcare handbook (called the "Summary Program Description") made the following promise every year:

> City Coverage for Medicare-Eligible Retirees
>
> When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. . . . The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare.

See, e.g., Pizzitola Aff., Ex. 12 at 14.

Since the introduction of Medicare and Medicare supplemental insurance in 1966, millions of elderly and disabled Retirees have enjoyed access to this simple, reliable, high-quality healthcare. With Medicare plus supplemental insurance, any Retiree can go to virtually any medical provider they want. Omdahl Aff. at ¶¶ 37, 63; Burns Aff. at ¶ 14; Barrios-Paolo Aff. at ¶ 37; Pizzitola Aff. at ¶ 12; Pizzitola Aff., Ex. 16 at 28 ("Medicare supplemental plans allow for the use of any provider"). And because nearly all medical providers in the United States follow the Medicare fee schedule (meaning they accept the Medicare-approved rate for services), having

Medicare plus supplemental insurance covers 100% of the cost of care.[7] Omdahl Aff. at ¶ 40; Ryan Aff. at ¶ 8; Pizzitola Aff. at ¶ 12. Thus, for the past half-century, any elderly or disabled Retiree with any medical problem has been able to walk into virtually any doctor's office, receive care, and walk out without paying a dime.[8] Moreover, if that doctor ordered a test, procedure, treatment, or therapy, the Retiree would receive that prescribed service without having to obtain the prior approval of an insurance company. Omdahl Aff. at ¶ 63; Pizzitola Aff. at ¶ 12. And if that Retiree needed around-the-clock or end-of-life care at a continuing care facility—many of which require residents to maintain Medicare plus supplemental insurance, *see, e.g.*, Archer Aff. at ¶ 14; Potter Aff. at ¶ 15; Miller Aff. at ¶ 6—she would have the health insurance coverage needed for admission, *see, e.g.*, *id.*; *see also* Ryan Aff. at ¶ 8.

City employment has many downsides. It generally involves grueling, thankless, and, in many cases, dangerous work, and the pay is much lower than in the private sector. Pizzitola Aff. at ¶ 8. Even in retirement, most former City workers can barely make ends meet: over 70,000 retirees survive on pensions of less than $1,500 a month; nearly 100,000 survive on less than $2,000; and over 150,000 survive on less than $3,000. Barrios-Paoli Aff. at ¶ 33; Pizzitola Aff. at ¶ 8.[9] However, City workers, unlike their private sector peers, could always rest easy knowing

---

[7] *See, e.g.,* U.S. Centers for Medicare and Medicaid Services, https://perma.cc/6LDC-HHDD (reporting that "98% of providers . . . agree to accept Medicare-allowed amounts as payment in full" for all for all Medicare-covered services).

[8] Medicare and Medicare supplemental plans do have relatively minor annual deductibles.

[9] *See also* 2021 NYC pension data compiled by the Empire Center, https://perma.cc/YV67-V895; *see also* New York City Office of the Actuary, Annual Comprehensive Financial Reports for the five New York City Retirement Systems, https://perma.cc/BU2Y-YJ97; Testimony of NYC Comptroller Alan G. Hevesi to the City Council Committee on Government Operations, January 31, 2000,
https://www.laguardiawagnerarchive.lagcc.cuny.edu/pages/FileBrowser.aspx?LinkToFile=FILE

that when they retired and became elderly or disabled, they would be taken care of for life with high-quality, hassle-free healthcare through Medicare plus supplemental insurance. That is a financial and psychological lifeline. Indeed, it is one of the main reasons many Retirees entered civil service in the first place, and what kept many from leaving despite the stress, low pay, and, in many cases, physical danger. Pizzitola Aff. at ¶ 9; Bentkowski Aff. at ¶¶ 3-4; Feinman Aff. at ¶¶ 3-4; Losinno Aff. at ¶ 5; J. Mihovics Aff. at ¶¶ 5, 10; Miller Aff. at ¶¶ 14, 16; Rhine Aff. at ¶¶ 5, 8; Rieser Aff. at ¶¶ 5, 6; Zimmerman Aff. at ¶ 4; *see also* Pizzitola Aff., Ex. 1.

B. Medicare Advantage

In the 1990s, a privatized, for-profit alternative to Medicare emerged called "Medicare Advantage." *See Ferlazzo v. 18th Ave. Hardware, Inc.*, 33 Misc. 3d 421, 424 (Sup. Ct. Bronx Cty. 2011) ("In 1997, the Medicare Advantage Program (f/k/a Medicare+Choice Program) was created as an alternative to the government Medicare program."). As the City's current Summary Program Description explains, "Medicare Advantage Plans replace both traditional Medicare and a Medicare supplemental plan with a single integrated program administered by an insurer."[10] Unlike Medicare supplemental plans—which pay secondary to, and merely fill the gaps in, Medicare—Medicare Advantage plans are the primary source of health insurance coverage for those enrolled. Ryan Aff. at ¶ 9; Burns Aff. at ¶ 14.[11]

S_DOC/Microfilms/05/011/0000/00001/052429/05.011.0000.00001.052429.10392001.PDF at 67-68

[10] *See, e.g.,* New York City Office of Labor Relations*, Health Benefits Program Summary Program Description*, https://www.nyc.gov/assets/olr/downloads/pdf/health/health-full-spd.pdf at 29

[11] *See, e.g.,* AARP, *How are Medigap and Medicare Advantage different?,* January 24, 2023, https://perma.cc/U6MB-J2Y6.

Despite the similarities in name, Medicare Advantage is completely different from Medicare. Under Medicare Advantage, a private, for-profit insurance company—not the federal government—controls one's health insurance benefits and access to care. The federal government pays these insurers a "capitated," or fixed, prospective amount to cover the care for each enrollee based on the expected healthcare needs of that individual. 42 U.S.C. §§ 1395w-23, 1395w-25. Thus, Medicare Advantage plans make money based on the spread between what the federal government pays them for a given enrollee and what they spend on that enrollee. This creates strong incentives for insurers to maximize this spread, which they famously do in three ways.

First, they increase the capitated amount they receive from the federal government by exaggerating enrollees' medical problems. As government investigations have revealed, insurers (including Aetna) have developed elaborate systems to make enrollees appear as sick as possible in order to maximize payment from the federal government.[12]

Second, insurers minimize the amount they spend on enrollees by steering them to preferred "in-network" medical providers who have contracted with the insurers to accept reduced rates. Omdahl Aff. at ¶ 42; Archer Aff. at ¶¶ 8, 10.[13] Indeed, in contrast to Medicare and Medicare supplemental plans (which have no networks), a defining feature of Medicare Advantage plans is their limited network of providers. Burns Aff. at ¶ 7; Ryan Aff. at ¶ 10; Potter Aff. at ¶ 13. If an enrollee wishes to see an out-of-network provider, she faces increased costs and the possibility

---

[12] *See, e.g.,* Reed Abelson and Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. TIMES, Oct. 8, 2022, https://perma.cc/N5QA-DK5M.

[13] *See also* Carol J. Wessels & Michelle Putz, *The Future of Assisted Living: A Crisis in the Making?*, Wis. Law., June 2020, at 43 ("Medicare Advantage plans have taken the place of Medicare, often providing one-third less in reimbursement . . . .").

that she could be refused care altogether. Archer Aff. at ¶ 8; Ryan Aff. at ¶¶ 26-30; Omdahl Aff. at ¶¶ 24, 26-27; Potter Aff. at ¶¶ 14, 18.

Third, insurers further minimize spending by denying coverage for medical services they believe are not "medically necessary," a process known as "prior authorization." Burns Aff. at ¶¶ 11-12; Barrios-Paoli Aff. at ¶¶ 15-18; Potter Aff. at ¶ 12. Thus, for example, if a doctor tells a patient she needs a medical procedure, and the insurer claims (without having examined the patient) that the procedure is not medically necessary, the patient will not be covered for that procedure, which means she will have to either pay out of pocket or "forgo[] the procedure altogether." *Cicio v. Does*, 321 F.3d 83, 98 (2d Cir. 2003). Insurers often make coverage decisions based on algorithms designed to deny necessary care.[14]

Given the powerful financial incentive for insurers to conclude that services are not medically necessary (which allows them to avoid paying and thereby maximize profits), it is not surprising that prior authorization regularly prevents and delays diagnosis and treatment, creating life-threatening risks for patients. Burns Aff. at ¶¶ 11-12; Barrios-Paoli Aff. at ¶¶ 15-18; Omdahl Aff. at ¶ 36; Potter Aff. at ¶ 12. In April 2022, the U.S. Department of Health and Human Services ("HHS") released a damning report revealing "widespread and persistent problems related to inappropriate denials of services and payment" caused by Medicare Advantage prior authorization requirements.[15] The report noted "millions" of unwarranted denials each year, which are so routine

[14] *See, e.g.,* Bob Herman and Casey Ross, *Senators probing largest Medicare Advantage plans over how algorithms factor in care denials*, STAT News, May 17, 2023, https://perma.cc/DBJ4-AUM5.

[15] *See, e.g.,* U.S. Dep't of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, April 2022, https://perma.cc/7TPN-Z6ZB ("HHS Report").

and unjustified that 75% of denials that get appealed are eventually reversed (but only after causing dangerous delays in care).[16]

In a recent survey conducted by the American Medical Association, 94% of physicians reported that prior authorization requirements caused delays in necessary treatment, and, as a result, 33% reported "serious adverse events" that required medical intervention, 19% reported a life-threatening event, and 9% reported a serious disability or permanent bodily damage.[17] The problem is so severe, Congress recently proposed bipartisan legislation to address it and is holding hearings right now to investigate it.[18]

While the numbers alone tell a distressing story, the HHS report also describes the harrowing human impact of Medicare Advantage's prior authorization requirements. Three examples from the report—all of which occurred in a single week during a random sampling exercise—illustrate this impact:

- A 72-year-old woman presented with a cancerous tumor in her breast.[19] Her Medicare Advantage plan denied the necessary surgery ordered by her doctor. That decision was reversed only after HHS happened to intervene.
- An 81-year-old with uterine cancer was improperly denied a CT scan that was "needed to determine the stage of the cancer, whether it had spread, and to determine the appropriate course of treatment."[20]

---

[16] HHS Report at PDF pp. 2, 5, 9.

[17] *See, e.g.,* American Medical Association, *2022 AMA prior authorization (PA) physician survey,* 2023, https://perma.cc/U2YU-8DGA.

[18] *See, e.g.,* Improving Seniors' Timely Access to Care Act, https://www.congress.gov/bill/117th-congress/house-bill/3173; Bob Herman and Casey Ross, *Senators probing largest Medicare Advantage plans over how algorithms factor in care denials*, STAT NEWS, May 17, 2023, https://perma.cc/DBJ4-AUM5.

[19] HHS Report, Appendix B, Example D385.

[20] *Id.*, Example D421.

- A Medicare Advantage plan refused to admit a 67-year-old stroke victim to an inpatient rehabilitation facility even though he presented with an "acute right-sided ischemic stroke and [was] seen at the emergency department with new onset slurred speech." [21] The man "had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore," according to the Medicare Benefit Policy Manual, "should have been under the frequent supervision of a rehabilitation physician."[22]

Notably, Aetna has been found to be the worst offender in the country when it comes to unwarranted denials of care. It has the highest prior authorization request denial rate (12%)—which is twice the national average (6%)—as well as the highest rate of appeals (20%) and second-highest rate of denials having to be overturned on appeal (90%).[23] In fact, multiple government investigations were recently launched into Aetna's flawed prior authorization process after one of its medical directors admitted under oath that he never looked at patients' records when deciding to deny care.[24]

Prior authorization is not just dangerous for patients, it is also a major hassle for medical providers, who have to complete the paperwork to obtain such authorization. Because of this hassle, and the reduced fees paid by Medicare Advantage plans, many doctors, hospitals, and continuing care facilities refuse to accept Medicare Advantage plans and the patients who have them. Archer Aff. at ¶ 9; Ryan Aff. at ¶ 28; Pizzitola Aff. at ¶ 20.

---

[21] *Id.*, Example D270.

[22] *Id.*

[23] *See, e.g.,* Jeannie Fuglesten Biniek and Nolan Sroczynski, *Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021*, KFF, Feb. 3, 2023 ("KFF Report"), https://perma.cc/4CHR-DZS9 (comparing data on Aetna (CVS) and other Medicare Advantage insurers).

[24] *See, e.g.,* Wayne Drash, *California launches investigation following stunning admission by Aetna medical director*, CNN, Feb. 11, 2018, https://perma.cc/M436-K4JD; *see also,* Healthcare Dive, *Aetna prior authorization probed by 2 states*, February 14, 2018, https://perma.cc/XZ8M-TG5U.

The main advantage of Medicare Advantage, as compared to Medicare supplemental insurance, is that it can be cheaper, since the federal government pays for it. *See, e.g.*, Barrios-Paoli Aff. at ¶¶ 52-53.[25] However, for retired City workers, for whom the City must "pay the entire cost" of Medicare supplemental insurance under the New York City Administrative Code § 12-126 ("Section 12-126"), this cost difference is largely irrelevant. That is why, although Medicare Advantage plans have been available to retired City workers for decades, very few have enrolled in such plans. The overwhelming majority of Retirees have always enrolled in one of the City's Medicare supplemental plans, specifically Senior Care. Pizzitola Aff. at ¶ 13.

In sum, the privatized, for-profit model of Medicare Advantage is completely different from, and far worse in many ways than, Medicare plus supplemental insurance, which Retirees have always had. *See RiseDelaware Inc. v. DeMatteis,* 2022 WL 11121549, at *2, 4 (Del. Super. Ct. Oct. 19, 2022) (explaining that a "Medicare Advantage plan is substantially different" from Medicare plus supplemental insurance); Ryan Aff. at ¶ 7; Barrios-Paoli Aff. at ¶¶ 9, 58; Potter Aff. at ¶ 8 ("Medicare Advantage is a money-making scam."), ¶¶ 10-17. The City itself has admitted that making healthcare a privatized, for-profit endeavor "result[s] in lower quality of health care and service, diminished access to care and to insurance coverage at increased cost, a decline in the health of the population, and the weakened financial health of medical providers." Gardener Affirmation ("Aff."), Ex. O at 4.

---

[25] *See also, e.g.*, Kate Ashford, *Medicare v. Medicare Advantage: Which Should I Choose?*, NerdWallet, https://perma.cc/7Y3L-WF5L (noting that "Medicare Advantage offers many $0-premium plans").

C. The City's Initial Attempt to Force Retirees into Medicare Advantage was Declared Unlawful

Despite the well-documented problems with Medicare Advantage, the City has been on a crusade since 2021 to force Retirees off of their Medicare supplemental insurance and into a Medicare Advantage plan. The reason is simple: by forcing a quarter-million Retirees off of their City-funded health insurance and into a federally funded Medicare Advantage plan, the City can reduce its expenses by hundreds of millions of dollars a year. Although this might sound like a reasonable way to alleviate the increasing costs of healthcare, it is not.

First, the switch to Medicare Advantage would not actually reduce healthcare costs; it would merely shift them onto Retirees and the federal government.

Second, as the Director of Budget Review for the New York City Independent Budget Office testified, the City's plan to withdraw funding for Retiree healthcare would not actually save City taxpayers any money.[26] That is because all cost savings are slated to go to "the administration and the unions" (with no "accountability or direct oversight"), not the City budget.[27]

Third, as described in the previous section, Medicare Advantage provides materially worse benefits compared to Medicare plus supplemental insurance. Thus, forcing Retirees into Medicare Advantage would jeopardize their health. Omdahl Aff. at ¶ 36; Burns Aff. at ¶ 5; Barrios-Paoli Aff. at ¶¶ 13-14, 18, 35, 47; Archer Aff. at ¶¶ 7, 10.

---

[26] Rosenberg Testimony at 1 (explaining how the switch to Medicare Advantage would "provide[] the city with no actual budgetary savings").

[27] *Id*. Moreover, because insurers overcharge the federal government for Medicare Advantage plans, switching Retirees to Medicare Advantage would likely "cost taxpayers . . . more than keeping them in original Medicare." Fred Schulte, *Medicare Advantage's cost to taxpayers has soared in recent years, research finds*, NPR, https://perma.cc/RA5W-NRZ9.

Fourth, and most importantly, the City cannot lawfully force Retirees into Medicare Advantage. It tried to do so in 2021 by making them pay for their Medicare supplemental insurance. In March 2022, this Court permanently enjoined that maneuver, holding that it violated Section 12-126. *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, No. 158815/2021, 2022 WL 624606, at *2 (Sup. Ct. N.Y. Cty. Mar. 3, 2022). In November 2022, the First Department unanimously affirmed. *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 210 A.D.3d 559 (1st Dep't 2022).

In *Campion*, the City offered Retirees a new Medicare Advantage plan as well as their existing Medicare supplemental insurance, but refused to pay for the Medicare supplemental insurance, arguing that Section 12-126 did not require it to do so. This Court and the First Department rejected that argument, holding that the City must pay up to the statutory cap for all available plans. Because it was not an issue in *Campion*, neither the parties nor the Court addressed whether the City could cease offering Medicare supplemental insurance altogether, as it seeks to do now.[28] Thus, this case presents an issue of first impression. However, it would make little sense for the City to be forbidden from charging Retirees for Medicare supplemental insurance (as this Court and the First Department previously held) but allowed to force Retirees to find and pay for such insurance on their own (as the City seeks to do here).

D. The City's New Scheme to Force Retirees into Medicare Advantage

After losing in court last year, the City turned to the City Council for relief. The City proposed legislation that would have allowed it to force Retirees into a Medicare Advantage plan

[28] In its decision, this Court noted that it was not deciding whether the City "must give retirees an option of [multiple] plans," since that question was also not before the Court. *Campion*, 2022 WL 624606, at *2.

by charging them for Medicare supplemental insurance, which most cannot afford. Pizzitola Aff. at ¶ 22.[29] The City Council swiftly rejected that proposal. *Id*. Councilmembers stated during public hearings that they wanted to preserve Retirees' access to Medicare plus supplemental insurance. *Id*.

Despite exhausting their legislative and litigation options, the City is refusing to give up on its Medicare Advantage aspirations. The allure of hundreds of millions of dollars flowing into discretionary accounts controlled by the Mayor and union leaders is apparently too powerful to resist. Accordingly, with the support of a divided Municipal Labor Committee (the umbrella organization representing the unions) and Martin Scheinman (the chair of a healthcare policy committee formed in 2018), the City has decided to employ what many have called the "nuclear option": it is going to take away Retirees' access to Medicare plus supplemental insurance and only allow them to enroll in a Medicare Advantage plan. In short, it is going to radically upend the policy that has governed Retiree healthcare for 57 years.

The City's Office of Labor Relations ("OLR") announced the general contours of this new healthcare policy in a letter dated March 10, 2023. Gardener Aff., Ex. A. According to OLR, on September 1, 2023, "the City will discontinue the Senior Care Plan and all [ten] other retiree plans," and will automatically enroll all Retirees in a new Aetna Medicare Advantage plan (the "Aetna MAP"). *Id*. Retirees who live in the City or in Nassau, Suffolk, Rockland, Orange, or Westchester Counties will also have the option of enrolling in an existing Medicare Advantage

[29] *See also* Chris Sommerfeldt, *NYC Council has no plan to pass bill that would let Mayor Adams charge retired city workers for healthcare: 'It's dead'*, NEW YORK DAILY NEWS, Jan. 19, 2023, https://www.nydailynews.com/news/politics/new-york-elections-government/ny-nyc-council-blocks-adams-bill-charging-retired-workers-insurance-20230119-evf3m2a7lvbxzftozpqmo2h3tq-story.html.

plan called HIP VIP, which has a very limited provider network that enrollees must stay within. *Id.*[30]

Retirees who do not wish to be automatically enrolled in the Aetna MAP will have from May 1 until June 30, 2023 to opt out. *Id.* However, Retirees who opt out must also waive their City health insurance coverage, meaning they will have to find and pay for their own health insurance on the open market and also pay for their own Medicare Part B premium and other costs. *Id.* In order to allow Retirees to make an informed opt-out decision, OLR promised Retirees they would receive "two comprehensive packages from Aetna with detailed information about the plan and resources available." *Id.* Many Retirees have never received either promised package. Pizzitola Aff. at ¶ 36.

Retirees who are forced off of their current Medicare supplemental plan and automatically enrolled in the Aetna MAP will experience a number of adverse changes to their healthcare. Below are a few examples.

First, unlike Medicare plus supplemental insurance, the Aetna MAP has a limited network of medical providers. As the City's contract with Aetna states, "health care providers and suppliers that are not contracted with [Aetna] to participate in the Provider Network are not required to accept the Plan and furnish Covered Benefits to Members." Gardener Aff., Ex. C at § 7.0. Those medical "providers that do not contract with [Aetna] are under no obligation to treat [Retirees], except in emergency situations." Gardener Aff., Ex. D at § 2.3; *see also* Gardener Aff., Ex. M at 2 (stating that Retirees who are enrolled in the Aetna MAP can only see providers who "accept

---

[30] *See, e.g.,* Pizzitola Aff. at ¶ 25; Office of Labor Relations, *Major Benefit Comparison: Senior Care, HIP VIP Premier Medicare Advantage HMO, and Aetna Medicare Advantage PPO*, https://perma.cc/ESM8-MZ8P.

your Aetna Medicare Advantage PPO plan"). As the hundreds of affidavits attached to this motion make clear, countless doctors, hospitals, and continuing care facilities have already decided they will not accept the Aetna MAP, and others could decide at any time not to accept it. Archer Aff. at ¶ 9; Barrios-Paoli Aff. at ¶¶ 13, 37, 39; Burns Aff. at ¶ 7-10; Ryan Aff. at ¶ 13; Pizzitola Aff., Ex. 1. Many continuing care facilities not only will not accept the Aetna MAP, they also specifically require residents to maintain Medicare plus supplemental insurance. Miller Aff. At ¶¶ 4, 6-7; Archer Aff. At ¶ 14; Ryan Aff. At ¶ 12; Pizzitola Aff. At ¶ 20; Pizzitola Aff., Ex. 1 at Forbes-Wolfe Aff. ¶¶ 4, 9. Retirees who rely on medical providers that do not accept the Aetna MAP will likely have to find new providers (which, in the case of continuing care facilities, means moving to a new home).

Second, as the Aetna contract states, there are various scenarios under the Aetna MAP where, "when you get medical care, you may need to pay the full cost." Gardener Aff., Ex. D at 37-38. For example, medical providers can choose to bill patients instead of Aetna. *See* Gardener Aff., Ex. K (explaining that "[i]f the provider refuses to bill the plan directly, you can still keep that appointment with the provider, but you will have to pay the provider's bill"). When that happens, Retirees will have to pay out of pocket for their own medical care, which (depending on the care) could be thousands, or even tens of thousands, of dollars. Even if Aetna eventually reimburses Retirees for these costs (after Retirees navigate Aetna's burdensome reimbursement request process), very few have the cash on hand to front the extraordinary cost of their medical care. Pizzitola Aff. At ¶ 48. And if Retirees fail to meet Aetna's strict deadlines and other procedural hurdles, they will not even be entitled to reimbursement. Gardener Aff., Ex. D at 37 (noting requirements "that you must meet to get paid back"), 39 ("If we decide that the medical

care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost." (emphasis in original)).

Third, Retirees will not be covered for a wide range of medical services and medications unless Aetna first deems them "medically necessary." Gardener Aff., Ex. C at § 12. For the first two years of the contract, the City has agreed to pay Aetna $15 per Retiree per month to limit the number of services and medications subject to this prior authorization requirement. *Id*. at § 12.2. However, even during that initial period, there are many critical services and medications that will require Aetna's prior authorization, which Aetna is famous for denying.[31] And after that initial period, there is no limit to the list of services and medications that may be subject to Aetna's prior authorization in the future. *Id*. at § 12.1, 12.2.

Fourth, out-of-network doctors are under no obligation to seek prior authorization. *Id*. at § 12 ("Non-contracted providers are not required to seek Prior Authorization for services from [Aetna.]"). Given the administrative burden of seeking prior authorization, many doctors will likely not do so since it is not required. *See, e.g.*, Potter Aff. At ¶ 18; Pizzitola Aff. At ¶ 20. However, a doctor's failure to seek prior authorization before providing services will not stop Aetna from denying coverage if Aetna later decides that these services were not medically necessary. Gardener Aff., Ex. C at § 12 (noting that, even if a provider fails to seek prior authorization, Aetna "reserves the right to retrospectively review claims submitted by non-contracted providers and may deny coverage if the services are not medically necessary and/or not

[31] These include acute hospital inpatient services; long-term acute care; acute physical rehabilitation; skilled nursing facility services; home care services; a long list of medications; various unidentified therapies, procedures, services, and technologies to be agreed to by Aetna and the City; all services that are not covered by Medicare; cosmetic services; and services that could be considered experimental and investigational in nature. Gardener Aff., Ex. C at § 12.

covered under the MA plan"). This creates enormous financial risk for Retirees. In the absence of a positive "coverage decision, if [Aetna] later determine[s] that the services are not covered or were not medically necessary, [Aetna] may deny coverage and [Retirees] will be responsible for the entire cost." Gardener Aff., Ex. D at Chapter 3, § 2.3. In other words, if a Retiree sees an out-of-network doctor who fails to obtain prior authorization before providing care, that Retiree will have to pay for that care herself if Aetna later decides it was not medically necessary.

Fifth, Retirees will have to pay co-pays for a variety of medical services (which is not the case under Retirees' existing insurance) and will face significantly increased prescription drug costs. Pizzitola Aff. At ¶¶ 29, 50; Gardener Aff., Exs. C, D.

In sum, the Aetna MAP will impose substantial new burdens on Retirees that will threaten their continuity of care and financial stability. Those who wish to avoid these burdens (because, for example, they cannot risk losing access to their medical providers) can opt out and try to find a Medicare supplemental plan on their own, which they must pay for. However, many of those who opt out will be denied coverage on the open market. Archer Aff. At ¶ 15; Burns Aff. At ¶¶ 13-24; Omdahl Aff. At ¶¶ 59-84. Indeed, in the 46 states that do not guarantee a right to Medicare supplemental insurance,[32] Retirees with significant medical conditions will be unable to pass underwriting for a Medicare supplemental plan. Archer Aff. at ¶ 15; Burns Aff. at ¶ 22-23; Barrios-Paoli Aff. at ¶ 40; Omdahl Aff. at ¶ 91. Those lucky enough to find a plan that will insure them will have to pay an exorbitant amount for that coverage, which few can afford. Barrios-Paoli Aff. at ¶¶ 32, 47; Omdahl Aff. at ¶¶ 84-85, 92; Burns Aff. At ¶ 22-23. And in many states, those who

---

[32] The four states that guarantee access to Medicare supplemental insurance are New York, Connecticut, Massachusetts, and Maine. Burns Aff. at ¶ 15; Omdahl Aff. at ¶¶ 66-69.

are under 65 and Medicare-eligible due to disability cannot access a Medicare supplemental plan at all on the open market. Burns Aff. at ¶ 17, 21-23; Omdahl Aff. at ¶¶ 88-89, 91-94; Barrios-Paoli Aff. at ¶ 40.

This puts Retirees undergoing treatment for serious illnesses in an impossible position: if the doctor treating them does not accept the Aetna MAP, they will have to opt out to ensure continuity of care; but they may not be able to find a plan that will insure them (at least not for an affordable amount), thus leaving them uninsured at the very moment when they need health insurance the most. This is a terrifying prospect for these fixed-income elderly and disabled Retirees.

ARGUMENT

A preliminary injunction should be granted where (1) petitioners have shown "a probability of success on the merits," (2) there is a "danger of irreparable injury in the absence of an injunction," and (3) the balance of equities tips in their favor. *Olcott v. 308 Owners Corp.*, 189 A.D.3d 687 (1st Dep't 2020). Each of these elements is satisfied here.

I. PETITIONERS ARE LIKELY TO SUCCEED ON THE MERITS

To establish a likelihood of success on the merits, "[a] prima facie showing of a reasonable probability of success is sufficient; actual proof of the petitioner's claims should be left to a full hearing on the merits." *Barbes Rest. Inc. v. ASRR Suzer 218, LLC*, 140 A.D.3d 430, 431 (1st Dep't 2016) (internal quotations omitted). A likelihood of success on the merits may be sufficiently established "even where the facts are in dispute and the evidence need not be conclusive." *Id.*

As explained below, Petitioners are likely to succeed on each of their causes of action. But even if this Court were to have doubts, even "grave doubts," regarding their likelihood of success—which it should not—a preliminary injunction would *still* be warranted given the serious

threat to the health and well-being of hundreds of thousands of senior citizens. *See Schlosser v. United Presbyterian Home at Syosset, Inc.*, 56 A.D.2d 615 (2d Dep't 1977) (affirming preliminary injunction in favor of senior citizens despite "grave doubts" on the merits because, if such relief were "not granted, any subsequent judgment might be rendered ineffectual"); *see also Republic of Lebanon v. Sotheby's*, 167 A.D.2d 142, 145 (1st Dep't 1990) (holding that risk of serious irreparable harm "reduce[s]" the showing required for likelihood of success on the merits).

A. Promissory Estoppel

For the past half-century, the City has consistently promised its employees that if they spent their career serving the City, when they turned 65 or became disabled, they would have access to City-funded health insurance coverage through a combination of Medicare plus Medicare supplemental insurance. As detailed in the hundreds of affidavits attached to this motion, Retirees all relied on this clear and unambiguous promise when making important employment, healthcare, financial, and other decisions throughout their lives. Pizzitola Aff. at ¶¶ 14-15, 17-19; Bentkowski Aff. at ¶¶ 3-5, 7; Engel Aff. at ¶¶ 3, 4-7, 8-11, 13; Feinman Aff. at ¶ 3-4, 6, 10; Losinno Aff. at ¶¶ 3, 5-6; J. Mihovics Aff. at ¶¶ 4-5, 8, 11; Miller Aff. at ¶¶ 3, 4, 14, 16; Rhine Aff. at ¶¶ 4-8; Rieser Aff. at ¶¶ 2-4; Zimmerman Aff. at ¶¶ 3-4; *see also* Pizzitola Aff., Ex. 1. Indeed, many decided to work—and risk their lives—for the City because of the promised healthcare benefits. Similarly, many chose their doctors, moved into continuing care facilities, decided when and where to retire, and made countless financial decisions based on the expectation that they would have Medicare plus supplemental insurance provided and paid for by the City, as promised. Because Retirees detrimentally relied on this promise, the City is estopped from denying them such insurance now.

The elements of a cause of action based upon promissory estoppel are: "(i) a sufficiently clear and unambiguous promise; (ii) reasonable reliance on the promise; and (iii) injury caused by

the reliance." *Castellotti v. Free*, 138 A.D.3d 198, 204 (1st Dep't 2016). Where, as here, these elements are met, a promisor cannot refuse to deliver on its promise.

Promissory estoppel applies with equal force to municipal defendants. *See Robinson v. New York*, 24 A.D.2d 260, 263 (1st Dep't 1965) (holding that "[p]rinciples of fair dealing apply to a municipal [defendant]"). In fact, where there is "manifest injustice," the doctrine may even be applied to "prevent [a governmental body] from performing its statutory duty or from rectifying an administrative error." *Agress v. Clarkstown Cent. Sch. Dist.*, 69 A.D.3d 769, 770-71 (2d Dep't 2010) (affirming viability of retired teacher's promissory estoppel claim allowing her "to receive continuing health insurance coverage from the School District" because she "made certain employment and insurance decisions based upon the earlier [erroneous] representations" by "one of the School District's employees . . . that she was entitled to receive" such coverage). "Manifest injustice" is found "where the plaintiff has been the victim of bureaucratic confusion and deficiencies" or "where a governmental subdivision acts or comports itself wrongfully or negligently, inducing reliance by a party who is entitled to rely and who changes his position to his detriment or prejudice." *Id*. *See also NRP Holdings LLC v. City of Buffalo*, 916 F.3d 177, 203 (2d Cir. 2019) ("New York appellate courts have permitted estoppel claims against municipal entities to proceed where individual persons relied to their detriment on a city's erroneous promises concerning . . . benefits as public employees."). Although that is exactly what happened here, no showing of manifest injustice is technically even required since the City has no "statutory duty" to cease offering Medicare supplemental insurance, nor is the City "rectifying an administrative error" by refusing to offer such insurance now.

Petitioners easily satisfy the elements of promissory estoppel.

i. The City has always promised employees that when they retired and became Medicare-eligible, they would be entitled to Medicare plus supplemental insurance.

The City is required by law to provide active and retired City workers and their dependents health insurance coverage through the City's Health Benefits Program. N.Y.C. Admin. Code § 12-126(a)(iv), (b)(1). In order for a Retiree to be eligible for such coverage, she must satisfy various requirements, including a minimum period of credited service (at least 10 to 15 years, depending on the job) at a minimum number of hours per week. *Id*. Retirees who satisfy these requirements are entitled to lifelong, City-funded health insurance coverage through the City's Health Benefits Program. *Id*.; *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 210 A.D.3d 559 (1st Dep't 2022).

The authoritative source of information about the Health Benefits Program is a handbook published by the City called the Summary Program Description ("SPD"). For over 50 years, the City has used the SPD as the primary tool to inform active and retired City workers and their dependents of the healthcare benefits they are entitled to under the Health Benefits Program.

Employees, retirees, and their dependents have always relied on the SPD when evaluating their healthcare rights and health insurance options. Pizzitola Aff. at ¶ 14. In fact, the City has repeatedly told them to do so. For instance, the City has instructed them: "Review this [SPD] as carefully as possible. You will find that it is a valuable resource . . . as a comprehensive guide to understanding your health benefits before you need to use them." Pizzitola Aff., Ex. 10 at 2. Readers were also advised: "This Summary Program Description provides you with a summary of your benefits under the New York City Health Benefits Program. Health insurance and the health care system can be complicated and confusing. This booklet was developed to help you to understand your benefits . . . ." *Id.*, Ex. 12 at 1 (Cover Letter).

Since the passage of Medicare nearly 60 years ago, *every single SPD* published by the City has promised workers that, when they retired and became Medicare-eligible, the Health Benefits Program would offer them City-funded health insurance coverage through a combination of Medicare plus Medicare supplemental insurance, and every SPD has listed multiple Medicare supplemental options for Retirees to choose from. Indeed, the SPDs stated that providing Medicare supplemental insurance was a *defining feature* of the Health Benefits Program. This promise was so important, many Retirees saved the first SPDs they received decades ago as conclusive proof of the healthcare they were entitled to upon their retirement. Pizzitola Aff. at ¶ 14.

We begin with the SPDs from the 1970s. These documents provided as follows:

> **NEW YORK CITY'S HEALTH PROGRAM PICKS UP WHERE MEDICARE LEAVES OFF**
>
> **At age 65+ (and thereafter), your first level of health benefits is provided by MEDICARE. The City's Health Insurance Program provides a second level of benefits intended to fill certain gaps in Medicare coverage**. . . . **The City's Health Program supplements MEDICARE but does not duplicate benefits which are available under MEDICARE**.

Pizzitola Aff., Ex. 2 at Cover Page, 2-3.[33]

This same promise of Medicare plus supplemental insurance was made in every subsequent SPD published by the City. Like the SPDs from the 1970s, SPDs from the 1980's stated:

> **At age 65+ (and thereafter), your first level of health benefits is provided by Medicare. The City's Employee Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage**. . . . **The City's Employee**

[33] Although Petitioners believe that SPDs from the late 1960s contained this same promise, they have not yet located documents that far back.

> **Health Program supplements Medicare but does not duplicate benefits which are available under Medicare**.

Pizzitola Aff., Ex. 3 at 12-13.

The City continued to make this exact same promise throughout the 1990s, even after Medicare Advantage officially came into existence in 1997. These SPDs, like their predecessors, stated:

> **City Coverage for Medicare-Eligible Retirees**
>
> **When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. . . . [T]he City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare.**

Pizzitola Aff., Ex. 7 at 49; *see also id.*, Ex. 4 at 39; *id.*, Ex. 5 at 46; *id.*, Ex. 6 at 47.

The SPDs from the 2000s contained this same promise:

> **City Coverage for Medicare-Eligible Retirees**
>
> **When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. . . . The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare.**

Pizzitola Aff., Ex. 9 at 51. *See also id.*, Ex. 8 at 51; *id.*, Ex. 10 at 14; *id.*, Ex. 11 at 14.

This promise continued unabated throughout the next decade as well, as SPDs published in the 2010s stated:

> **City Coverage for Medicare-Eligible Retirees**
>
> **When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. . . . The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare.**

Pizzitola Aff., Ex. 12 at 14. *See also id.*, Ex. 13 at 14; *id.*, Ex. 14 at 14; *id.*, Ex. 15 at 14.

The City has repeated this promise all the way to the present decade, as SPDs in the 2020s stated: "**CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES: The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare**." *Id.*, Ex. 16 at 19; *see also id.*, Ex. 17 at 19.

Nowhere in these SPDs did the City qualify its promise by warning employees that someday, when they became eligible for Medicare, the City might suddenly deny them access to Medicare and Medicare supplemental insurance, or that it might force them into a Medicare Advantage plan. Up until now, such a drastic and unlawful maneuver was unthinkable.

The City's promise of Medicare plus supplemental insurance was not confined to the SPDs. The City repeated this promise in countless other documents relied on by employees and retirees. Although these documents are too numerous to catalogue here, we offer a few representative examples. One such example is a list of frequently asked questions regarding retiree healthcare published by the City's Office of Human Resources Solutions. *Id.*, Ex. 18. Question number eight asked: "What do I do when I and/or my dependent becomes eligible for Medicare?" *Id*. at 3. The listed answer repeats the promise made in the SPDs:

> **When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special**

> **provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. . . . The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare.**

Id.

1. Likewise, "Summary of Benefits" booklets published over the years by individual City agencies stated: "**If you are a Medicare-eligible retiree, Medicare provides your first level of health benefits. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage**." *Id.*, Ex. 19 at 7. Similarly, myriad pension-related manuals and handbooks stated that when retirees turn 65, "**Medicare becomes Primary, and the City coverage is continued as supplemental**." *Id.*, Ex. 20 at 6; *id.*, Ex. 21 at 2-3.

Based on the City's clear and repeated promise, the City's labor unions have consistently advised their members that when they retired and became eligible for Medicare, they would be entitled to Medicare plus supplemental insurance. *See, e.g.*, *id.*, Ex. 22 at 1 ("**When you sign up for Medicare, your city-provided health plan automatically becomes a Medicare supplement (sometimes called a Medi-Gap policy). . . . NYC municipal retirees do not need to purchase any additional coverage, since their city coverage becomes the Medicare supplement automatically**."); *id.*, Ex. 23 at 8 (explaining that "**[w]hen you become eligible for Medicare, . . . Medicare becomes your primary provider and your city plan becomes your secondary carrier," meaning that "your city plan fills in some of the gaps" of Medicare**). Union representatives are agents of the City in this context because the City has tasked them with informing members of their healthcare rights and benefits. Pizzitola Aff. at ¶ 15.

The City's healthcare promise was not just communicated in writing. City officials and human resource officers also verbally assured employees over the years that, if they served the City for the statutorily required amount of time, they and their dependents would be entitled to Medicare plus supplemental insurance when they became Medicare-eligible. Pizzitola Aff. at ¶¶ 14; Pizzitola Aff., Ex. 1; Barrios-Paoli Aff. at ¶¶ 27-28. This is confirmed by scores of affidavits, both from individuals who were made this promise *and* City officials who communicated the promise. *Id*. Indeed, former City Commissioner Lilliam Barrios-Paoli, who served four different mayors in various leadership roles, including as head of the Departments of Employment, Personnel, and Human Resources Administration, testified that "[e]very year for more than 50 years," City officials (including herself) told employees and retirees they would be entitled to Medicare plus a choice of Medicare supplemental plans when they became Medicare-eligible. Barrios-Paoli Aff. at ¶¶ 19, 27-28. Commissioner Barrios-Paoli further testified that the City used this promise as "an essential recruiting and retention tool." *Id.* at ¶ 27.

In sum, for over 50 years, the City's promise of Medicare plus supplemental insurance has been clear, consistent, unqualified, and ubiquitous. This promise was made to all current Retirees *before* they accepted employment with the City, *during* their employment with the City, and *after* their employment with the City. And, up until today, the City has always honored this promise. Since the introduction of Medicare in the 1960s, every single retired City worker has been given the option of enrolling in Medicare plus one of several City-funded Medicare supplemental plans. Pizzitola Aff. at ¶ 10. It is hard to imagine a clearer, more consistent, or more enduring promise by any employer.

Moreover, it is important to emphasize that the City's repeated promise of Medicare plus supplemental insurance was not time-limited. As reflected in the bolded quotes above, the City

did not merely promise this health insurance for a specific period of time. Rather, the City assured workers and retirees that the Health Benefits Program would provide such insurance "[w]hen you or one of your dependents becomes eligible for Medicare," *regardless of when that might be*. Providing Medicare supplemental insurance was described as being an inherent and permanent feature of the Health Benefits Program.

The City always characterized Medicare plus supplemental insurance as being an essential part of the Health Benefits Program because, under the law, it is. Section 12-126 governs Retirees' healthcare rights. It was enacted in 1967, when the only health insurance available to Medicare-eligible retirees was Medicare and supplemental insurance. Section 12-126 requires the City to provide and pay for this insurance. Indeed, Section 12-126 states that: (1) the City's "health insurance coverage [for Retirees] is *predicated* on [their] enrollment in [Medicare]," the "premium" for which "the City shall reimburse"; and (2) "the City" must offer a "program" of health insurance plans and "pay the *entire* cost" of these plans up to a specified amount. N.Y.C. Admin. Code § 12-126(a)(iv), (b)(1) (emphasis added). Because the City pays the *entire* cost of Medicare supplemental plans, but does *not* pay the entire cost of Medicare Advantage plans (because they are federally funded), the City cannot satisfy its obligations under Section 12-126 by offering only Medicare Advantage.

Further, before the City could pay for Retirees' health insurance under Section 12-126, a state law authorizing such payment had to be passed. That state law was N.Y. State General City Law ("GCL") § 20(29-b). GCL § 20(29-b) empowers the City to "reimburse any retired officer or employee who . . . is enrolled in a choice of health plans program offered by the city . . . for premium charges for *supplementary medical insurance* benefits under the federal old-age,

survivors and disability insurance benefit program." Thus, state law only authorizes Section 12-126 to the extent the City's Health Benefits Program offers Medicare supplemental insurance.

In conclusion, under Section 12-126 and its authorizing statute, the City's Health Benefits Program must provide Medicare supplemental insurance. That is why, since the enactment of these laws over half a century ago, the City has always promised and provided such insurance.

ii. Retirees reasonably relied on the City's promise.

As the hundreds of attached affidavits reflect, Retirees relied on the City's promise that when they became Medicare-eligible they would be entitled to Medicare plus supplemental insurance. Pizzitola Aff., Ex. 1; Pizzitola Aff. at ¶¶ 14-15, 17-19; Bentkowski Aff. at ¶¶ 3-5, 7; Engel Aff. at ¶¶ 3, 4-7, 8-11, 13; Feinman Aff. at ¶ 3-4, 6, 10; Losinno Aff. at ¶¶ 3, 5-6; J. Mihovics Aff. at ¶¶ 4-5, 8, 11; Miller Aff. at ¶¶ 3, 4, 14, 16; Rhine Aff. at ¶¶ 4-8; Rieser Aff. at ¶¶ 2-4; Zimmerman Aff. at ¶¶ 3-4. Because this promise was (i) consistently made and honored for over 50 years, and (ii) communicated in countless City documents—including the SPDs, which are the authoritative source of information about Retiree healthcare benefits and on which the City itself urged reliance—and in countless verbal communications with City representatives, there can be no question that this reliance was reasonable.

iii. Retirees have relied to their detriment on the City's promise.

"An estoppel may be imposed in such cases when the [City's false promise] has induced justifiable reliance by a party who then changed his position to his detriment." *Allen v. Bd. of Educ. of Union Free Sch. Dist. No. 20*, 168 A.D.2d 403, 404 (2d Dep't 1990). Retirees have all made important—and irreversible—employment, financial, medical, and other life decisions in reliance on the City's promise of City-funded Medicare plus supplemental insurance. These Retirees would have made countless different decisions had they known that the City would not

honor this promise. Pizzitola Aff. at ¶¶ 17, 19; Pizzitola Aff., Ex. 1. Below are some examples taken from the hundreds of affidavits attached to this motion.

First, Retirees chose to grind out low-paying, stressful, and, in many cases, dangerous careers in public service based in large part on the first-class healthcare benefits they were promised in retirement. Pizzitola Aff. at ¶ 9; Bentkowski Aff. at ¶¶ 3 4; Feinman Aff. at ¶¶ 3-4; Losinno Aff. at ¶ 5; J. Mihovics Aff. at ¶¶ 5, 10; Miller Aff. at ¶¶ 14, 16; Rhine Aff. at ¶¶ 5, 8; Rieser Aff. at ¶¶ 5, 6; Zimmerman Aff. at ¶ 4; *see also* Pizzitola Aff., Ex. 1. For instance, countless first responders sacrificed their health and safety—including by rushing into burning buildings, inhaling toxic fumes at Ground Zero, and performing first aid on people with highly infectious diseases—in reliance on the City's promise that when they became old and disabled, the City would provide them Medicare plus supplemental insurance and not some inferior form of insurance like Medicare Advantage. Now, many are sick with cancer and other life-threatening illnesses caused by their heroic service. They cannot risk losing the doctors and Medicare benefits on which they have long depended by enrolling in the Aetna MAP. These Retirees detrimentally relied on the City's healthcare promise every day they risked their lives at work. As numerous Retirees testified in their affidavits, they would have pursued safer and/or more lucrative careers in the private sector had they known the City would refuse to provide them Medicare plus supplemental insurance. *See, e.g.*, Feinman Aff. at ¶ 3-4; J. Mihovics Aff. at ¶ 10; Miller Aff. at ¶¶ 14, 16; Rhine Aff. at ¶ 8; Rieser Aff. at ¶ 6; Pizzitola Aff. at ¶¶ 17, 19; Pizzitola Aff., Ex. 1.

Second, because Retirees were led to believe that the City would always provide them with Medicare plus supplemental insurance, they had no reason to save or budget for this expense, which costs several thousand dollars a year. Pizzitola Aff. at ¶¶ 17, 19; Pizzitola Aff., Ex. 1; Barrios-Paoli Aff. at ¶ 31; Bentkowski Aff. at ¶ 8; Engel Aff. at ¶ 11; Feinman Aff. at ¶ 10; Lossino

Aff. at ¶¶ 5, 7; J. Mihovics Aff. at ¶ 11; Miller Aff. at ¶ 16; Rhine Aff. at ¶ 6; Rieser Aff. at ¶ 18; Zimmerman Aff. at ¶ 15. Now that they are retired and no longer have any income, it is too late. Few can afford this expense, as most live below or near the poverty line.[34] As mentioned previously, over 70,000 retirees survive on pensions of less than $1,500 a month; nearly 100,000 survive on less than $2,000; and over 150,000 survive on less than $3,000. Yet, unless a preliminary injunction is issued, many will have no choice but to pay for Medicare plus supplemental insurance in order to keep their doctors, avoid Aetna's dangerous prior authorization requirements, and retain other important Medicare benefits. *See, e.g.*, Pizzitola Aff., Ex. 1. Because Retirees survive on small, fixed incomes, they must carefully budget every expense. Pizzitola Aff. at ¶ 17. Had they known they would need to pay many thousands of dollars a year for their healthcare, they would have drastically altered their savings, spending, and investment strategies long ago, and many would have delayed retirement or taken a second job in order to afford this increased expense. *See, e.g.*, J. Mihovics Aff. at ¶ 11; Rhine Aff. at ¶ 8; Pizzitola Aff. at ¶¶ 17, 19; Pizzitola Aff., Ex. 1.

Third, because Medicare plus supplemental insurance is accepted everywhere by virtually everyone, Retirees expecting to be covered by such insurance selected their doctors, hospitals, and continuing care facilities without regard to whether these medical providers might accept Medicare Advantage (many do not). These Retirees relied to their detriment on the City's healthcare promise, since many of their doctors, hospitals, and continuing care facilities will not accept the Aetna MAP (or any Medicare Advantage plan for that matter). *See, e.g.*, Pizzitola Aff.at ¶¶ 17,

---

[34] The poverty threshold for the federal nutritional program is $2,096 a month for a one-person household and $2,823 a month for a two-person household. New York State Department of Health, *2022-23 Federal Income Guidelines*. https://perma.cc/R5EL-324N.

19; Pizzitola Aff., Ex. 1; Miller Aff.at ¶¶ 4, 6-7; Burns Aff.at ¶ 7-10; Barrios-Paoli Aff.at ¶¶ 13, 37, 39. Had they known they would be forced into Medicare Advantage, these Retirees—particularly those in the middle of treatment for serious illnesses such as cancer—would have chosen medical providers that accept such insurance. *Id*. Now they will have to either pay for their own healthcare or scramble to find new medical providers. For the many Retirees who live in continuing care facilities that do not accept Medicare Advantage and require residents to maintain Medicare plus supplemental insurance, they are at risk of needing to find a new home, a daunting prospect for these infirm, elderly individuals living on fixed incomes. *See, e.g.*, Miller Aff.at ¶ 4, 6-7; Pizzitola Aff.at ¶ 20; Pizzitola Aff., Ex. 1 at Forbes-Wolfe Aff. ¶¶ 4, 9; *cf.* Archer Aff.at ¶ 14; Potter Aff.at ¶ 15. These Retirees expected to reside in these facilities for the remainder of their lives and receive end-of-life care there.

Lastly, because Retirees never thought they would have to purchase a Medicare supplemental plan on the open market, they made decisions about where to retire without regard to whether the state they moved to would guarantee their right to enroll in a Medicare supplemental plan. Many Retirees live outside of New York. Pizzitola Aff., Ex. 1; Barrios-Paoli Aff.at ¶ 40. In 94% of those states, insurers can, and regularly do, refuse to underwrite Medicare supplemental plans for individuals with serious medical conditions, which is the case for many of these Retirees; and in many of these states, Medicare supplemental insurance is unavailable to Retirees under 65 who are Medicare-eligible due to disability. Burns Aff.at ¶ 17, 21-23; Omdahl Aff.at ¶¶ 88-89, 91; Barrios-Paoli Aff.at ¶ 40. Retirees who live in these states and opt out of the Aetna MAP in order to maintain continuity of care may be unable to enroll in a Medicare supplemental plan at all, and therefore risk being uninsured. The detrimental reliance of Retirees who moved to these states is obvious and potentially catastrophic.

In short, because Retirees reasonably relied to their detriment on the City's promise of Medicare plus supplemental insurance, the City is estopped from denying them such coverage.

An overwhelming body of caselaw confirms this. Indeed, courts routinely apply promissory estoppel against municipal defendants in analogous circumstances. For example, in *Agress*, the Second Department held that if the plaintiff, a retired teacher, had been told even once by a single benefits officer that the school district would provide her with continuing health insurance coverage and she then made any "decisions based upon [these] representations," the school district would be estopped from denying her such coverage. 69 A.D.3d at 771. The facts in the present case are even more compelling: the City's promise was made not just by a lone individual in a stray conversation; it was repeated by the City in countless documents and conversations for over half a century.

Allen, another Second Department case, is similar to *Agress*. In *Allen*, the defendant board of education had been paying 100% of the health insurance premiums for its retirees, and subsequently altered its policy to reduce its premium contributions for retirees over the age of 65. The retirees asserted a promissory estoppel claim against the board to compel it to continue paying 100% of their insurance premiums. The Second Department held that the claim was viable, noting evidence that several plaintiffs had detrimentally relied on "representations made to them that they had a secure right to have the defendants make lifetime health insurance premium contributions." 168 A.D.2d at 404.

Numerous other cases have likewise held that plaintiffs were entitled to health insurance and other employment benefits promised to them in similar circumstances. *See, e.g.*, *Vassenelli v. City of Syracuse*, 138 A.D.3d 1471, 1475 (4th Dep't 2016) (upholding viability of promissory estoppel claim requiring city to continue paying healthcare costs based on plaintiff's reliance on

city's past "payment for services and medications"); *Branca v. Bd. of Educ., Sachem Cent. Sch. Dist. at Holbrook*, 239 A.D.2d 494, 496 (2d Dep't 1997) (recognizing viability of estoppel claim in action to compel school district to pay promised compensation and benefits); *see also Abbruscato v. Empire Blue Cross and Blue Shield*, 274 F.3d 90, 101 (2d Cir. 2001) (approving estoppel claim based on retirees' reliance on insurance coverage promise made in summary plan description, despite reservation-of-rights clause).[35]

B. Life-Threatening Disruption of Care

Unless an injunction is issued, the City's ruthless campaign to force a quarter-million elderly and disabled Retirees off of their longstanding health insurance and into a Medicare Advantage plan will cause incalculable suffering. One particular category of suffering is so extreme and senseless, it renders the entire scheme arbitrary, capricious, and an abuse of discretion, in violation of CPLR 7803(3).

As noted above, many Retirees live outside of New York. When they retired, they generally moved to states with a lower cost of living so that they could survive on their limited pensions. A substantial number of these Retirees are being treated for serious illnesses by medical providers who will not accept Medicare Advantage plans in general or the Aetna MAP specifically.

---

[35] *Abbruscato* is particularly instructive, as it involved a promise similar to the one at issue here made in a document similar to the City's SPD. Specifically, the defendant employer communicated the following promise in a summary plan description of its group life insurance:

> If you retire . . . at age 65 or older with 10 or more years of full-time service; or at age 55 or older with 20 or more years of full-time service; or at any age, with 30 or more years of full-time service, your basic life insurance will be reduced by 10% as of your retirement date, and by an equal amount on each of the next four anniversaries of your retirement date so that 50% of your life insurance coverage remains in force for the rest of your life, at no cost to you.

Pizzitola Aff.at ¶¶ 17, 20; Pizzitola Aff., Ex. 1. Accordingly, in order for these Retirees to maintain continuity of care in the midst of potentially life-saving treatment, they will need to opt out of the Aetna MAP and find a Medicare supplemental plan on the open market. Indeed, their lives may depend on it. However, in 46 states (where many Retirees live), insurance companies can and will refuse to underwrite a Medicare supplemental plan for individuals with serious health problems, which these mid-treatment Retirees have.[36] Archer Aff.at ¶ 15; Burns Aff.at ¶ 22; Barrios-Paoli Aff.at ¶ 40; Omdahl Aff.at ¶ 91. And in many states, Retirees who are Medicare-eligible due to disability may not even be able to obtain a Medicare supplemental plan if they are under 65. Burns Aff.at ¶ 17, 21-23; Omdahl Aff.at ¶¶ 88-89, 91; Barrios-Paoli Aff.at ¶ 40. The City itself acknowledges that many Retirees will be unable to get Medicare supplemental coverage on their own.[37] Those lucky enough to find an insurer to cover them will be charged an exorbitant amount, which few can afford. Barrios-Paoli Aff.at ¶¶ 32, 47; Omdahl Aff.at ¶¶ 84, 92; Burns Aff.at ¶ 24.

Therefore, if the City is allowed to kick these Retirees off of their current Medicare supplemental plan, they will either be left uninsured or forced to switch medical providers in the middle of life-saving treatment, which is extremely dangerous. Barrios-Paoli Aff.at ¶¶ 13-14, 18, 35, 47; Burns Aff.at ¶ 5; Omdahl Aff.at ¶ 36; Archer Aff.at ¶¶ 7, 10.

The case of Petitioner Michelle Feinman is instructive, and heartbreaking. She lives in Arizona and suffers from a host of medical problems—including quadriplegia and lung damage—that require regular medical care. *See* Feinman Aff.at ¶¶ 2, 5, 7-8. The two doctors on whom she

---

[36] The four states that guarantee access to Medicare supplemental insurance are New York, Connecticut, Massachusetts, and Maine. Burns Aff.at ¶ 15; Omdahl Aff.at ¶¶ 66-69.

[37] *See, e.g.,* NYC Office of Labor Relations, *NYC Health Benefits Program*,, https://perma.cc/A5CH-FPMS (admitting that some Retirees who opt out of the Aetna MAP will "experience a loss of coverage").

most depends have said definitively they will not accept the Aetna MAP, and her other medical providers have said they likely will not accept it either. *Id*. at ¶ 9. Unless she remains on Medicare plus supplemental insurance, which will allow her to continue receiving treatment from her doctors, she "may not be able to physically move in the near future." *Id*. at ¶ 11. Tragically, her significant medical problems, which are the reason she needs Medicare supplemental insurance, are also the reason she may not be able to obtain that insurance, since they will make it difficult, if not impossible, for her to pass underwriting. Archer Aff.at ¶ 15; Burns Aff.at ¶ 22; Barrios-Paoli Aff.at ¶ 40; Omdahl Aff.at ¶ 91. And because she is under 65 and living in Arizona, she might not have access to a Medicare supplemental plan even if she could pass underwriting. Burns Aff.at ¶ 17, 21-23; Omdahl Aff.at ¶¶ 88-89, 91; Barrios-Paoli Aff.at ¶ 40.

Retiree Richard Sherman, who lives in Florida, is in a similar boat. He is receiving treatment for a rare form of leukemia as well as lung cancer, asthma, emphysema, and severe COPD. Pizzitola Aff., Ex. 1 at Sherman Aff.. Like Ms. Feinman, the medical providers who are treating him will not accept the Aetna MAP. However, because he has uninsurable medical conditions, he will likely be unable to obtain Medicare supplemental insurance coverage. Therefore, absent injunctive relief, he will face multiple life-threatening diseases without adequate insurance coverage.

There are countless Retirees living this same nightmare. *See, e.g.*, Pizzitola Aff., Ex. 1. The attached affidavits offer a window into the world of some of these individuals, who are battling fatal illnesses that could prevent them from getting Medicare supplemental insurance coverage, but who need that coverage in order to continue receiving treatment from their medical providers. *See, e.g.*, Bentkowski Aff.; Zimmerman Aff.; Pizzitola Aff., Ex. 1 at Goldberg Aff.; *id.* at Karlsen Aff.; *id.* at Mirsky Aff.; *id.* at Hill Aff.; *id.* at Dooley Aff.; *id.* at Sherman Aff.. While these

Retirees are fighting for their lives and in need of constant medical care from their doctors, they now face the frightening prospect of either being uninsured or having to find new doctors.

By forcing this crisis on low-income elderly and disabled Retirees in treatment for life-threatening illnesses, the City's new healthcare policy is not only arbitrary, capricious, and an abuse of discretion (and thereby unlawful), it is also immoral. No rational or humane healthcare policy would force such suffering on such a vulnerable population, particularly those who dedicated their lives to this City in reliance on a promise of Medicare plus supplemental insurance.

C. Moratorium Law

Several Petitioners and a large percentage of Retirees are former public-school employees. They have an added level of healthcare protection under the Retiree Health Insurance Moratorium Act, Chapter 729 of the Laws of 1994 (as amended by L 2009, Ch. 30 and L 2009, ch. 501 § 14) ("Moratorium Law"). The Moratorium Law prohibits a school board or district "from diminishing the health insurance benefits provided to retirees and their dependents or the contributions such board or district makes for such health insurance coverage" unless the board or district makes "a corresponding diminution of benefits or contributions" for active employees. *Id.* The City is violating this law in two separate respects: it is diminishing both the *benefits* provided to Retirees *and* the *contributions* made for their health insurance coverage without a corresponding diminution of benefits or contributions for active employees.

i. The Legislature passed the Moratorium Law to prevent exactly what the City is doing here.

The Moratorium Law was passed in 1994—and renewed every year until it was made permanent in 2010—to prevent exactly what the City is doing here: cutting costs on the backs of retirees. Recognizing that retirees are in a "very precarious position" because they are no longer

protected by the collective bargaining process, the Legislature passed the Moratorium Law as "a very reasonable protection that retirees need." Gardener Aff., Ex. P at McKinney's 1997 Session Law News of New York. "The law provides that school districts may reduce neither the level of health insurance coverage nor their contribution toward its cost for retirees, unless the reduction applies equally to active employees . . . . The law does not, however, prevent school districts from taking cost-cutting measures, so long as these apply equally to active employees and retirees." Gardener Aff., Ex. P at McKinney's 2004 Session Laws of New York. Thus, in order for "school districts [to] tak[e] cost-cutting measures," they must "apply *equally* to active employees and retirees." *Id*. (emphasis added).

New York courts have repeatedly emphasized this same purpose: that is, the Moratorium Law was designed to protect the rights of retirees who "are not represented in the collective bargaining process [and therefore] powerless to stop unilateral depreciation or even elimination of health insurance benefits once the contract under which they retired has expired." *Bryant v. Bd. Of Edu.*, 21 A.D.3d 1134, 1135 (3d Dep't 2005) (quoting Assembly Mem. in Support, 1996 McKinney's Session Laws of N.Y., at 2049-50); *see also Jones v. Bd. of Educ. of Watertown City Sch. Dist.*, 6 Misc.3d 1035(A), at *17 (Sup. Ct. Jefferson Cty. 2005), *aff'd*, 30 A.D.3d 967 (4th Dep't 2006) ("It is apparent, from the basic premise and overall effect of the law, that the legislature intended to protect and preserve the health insurance benefits available to school district retirees, in light of tightening budgetary constraints that may make curtailing such benefits seem an attractive and expedient way to cut costs."). So too have courts emphasized that the Moratorium Law "sets a minimum baseline or floor for retiree health benefits." *Perrotta v. Syosset Central Sch. Dist.*, 210 A.D.3d 986, 988 (2d Dep't 2022) (cleaned up) (collecting cases).

The City's decision to eliminate Medicare plus supplemental insurance and replace it with a single, inferior Medicare Advantage plan does just what the Legislature sought to prevent: it drastically reduces both the healthcare contributions and benefits for Retirees, who are "powerless" to stop it through the collective bargaining process, without a corresponding reduction for active employees. The Mayor and a few powerful unions essentially sold out Retirees in order to enrich themselves by hundreds of millions of dollars a year, which is unlawful.

ii. The City is diminishing its healthcare contributions for Retirees without a corresponding diminution for active employees.

As noted above, the Moratorium law prohibits two types of acts. One of them is imposing "cost-cutting measures" that do not "apply equally to active employees and retirees." Gardener Aff., Ex. P at McKinney's 2004 Session Laws of New York. That precisely describes what the City is doing here. By forcing Retirees into the Aetna MAP, the City will spend only $15 per Retiree per month on those enrolled in the plan, as compared to approximately $192 per Retiree per month for their existing Medicare supplemental insurance.[38] That is more than a 92% cut in spending on Retiree healthcare. There has been no remotely comparable cost-cutting measures for active employees. Pizzitola Aff. at ¶ 34. Just the opposite: the City has *increased* spending on employee healthcare every year. *Id*. This Court should enjoin the City's new healthcare policy based on this unequal cost-cutting alone.

Courts have enjoined healthcare policies based on analogous facts. For example, in *Jones v. Board of Education of Watertown City School District*, the Fourth Department found a Moratorium Law violation where a school district reduced its contributions to the health insurance

---

[38] *See Campion*, 210 A.D.3d at 560. For those enrolled in HIP VIP, the City only pays $7.50 a month. *See* City's Br., *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,* No. 158815/2021, 2022 WL 17078320 (1st Dep't 2022).

premiums of retirees by 10%, while reducing its contributions to the premiums of active employees by only 4%. 30 A.D.3d 967, 970 (4th Dep't 2006). In *Perrotta v. Syosset Central School District*, the Second Department likewise found a Moratorium Law violation where a school district reduced the health insurance contributions for retirees by 30-45% without a corresponding reduction for active employees. 210 A.D.3d 986, 988-89 (2d Dep't 2022).

iii. The City is also diminishing Retirees' healthcare benefits without a corresponding diminution for active employees.

Not only is the City cutting costs on the backs of Retirees, it is also disproportionately diminishing their healthcare benefits. That provides a separate basis for an injunction.

The City is diminishing Retirees' healthcare benefits through: (1) the imposition of co-pays for medical services; (2) a significant increase in prescription drug costs; (3) the elimination of healthcare choice and access to care; and (4) the imposition of prior authorization.

a. Co-pays

Retirees have always had no co-pays for medical services.[39] Pizzitola Aff. ¶ 29. Under the Aetna MAP, however, they will now be subject to a $15 co-pay for numerous medical services, including specialist visits. Gardener Aff., Ex. C. The Fourth Department found a Moratorium Law violation in a case involving nearly identical facts. In *Anderson v. Niagara Falls City School District*, retirees were transferred from a traditional Medicare plan that had no co-pays for in-network services to a Medicare Advantage plan with co-pays for such services. 125 A.D.3d 1407 (4th Dep't 2015); *see also* Brief for Petitioner, *In the Matter of Anderson, et al. v. Niagara Falls*

---

[39] In 2022, the City and EmblemHealth began to unlawfully impose co-pays on Retirees enrolled in Senior Care. Because the Senior Care contract prohibits co-pays for medical services, this Court enjoined the continued imposition of co-pays. *See Bianculli v. City of New York Office of Labor Relations*, No. 160234/2022, 2023 WL 158773, at *3 (N.Y. Sup. Ct. Jan. 11, 2023). That injunction was affirmed on appeal. 2023 WL 3633367 (1st Dep't May 25, 2023).

City Sch. Dist. et al., 2014 WL 9940082 (explaining the differences in the plans). The respondent school district argued that it had made up for that cost difference by depositing $600 a year into a medical reimbursement account for each retiree. 125 A.D.3d at 1408-09. But the court rejected that argument and held that the school district had violated the Moratorium Law. *Id.* at 1409. The City has likewise violated the Moratorium Law here by forcing Retirees into an inferior healthcare plan with, among other things, higher co-pays, and has imposed no corresponding increase in co-pays for active employees. Although the City has publicly touted the fact that the Aetna MAP has a $1,500 annual out-of-pocket maximum, whereas the plan most Retirees are currently in (Senior Care) has no out-of-pocket maximum, that argument is a red herring: under Senior Care, Retirees have essentially no out-of-pocket costs. Thus, the $1,500 out-of-pocket maximum—like the $600 medical reimbursement account contribution in *Anderson*—cannot compensate for the imposition of new $15 co-pays.

The fact that co-pays for active employees will remain the same—*i.e.*, that actives will experience no corresponding "diminution" in benefits—is the end the Moratorium Law inquiry. *See, e.g.*, *Matter of Baker v. Bd. of Educ.*, 29 A.D.3d 574, 575 (2d Dep't 2006) (finding Moratorium Law violation where school board stopped reimbursing retirees for Medicare Part B premiums and there was "no indication that the District made a corresponding diminution in the health insurance benefits or contributions of active employees"). But it also bears mention that active employees will continue to have several health insurance options with *no or lower* co-pays.[40] These options include GHI-CBP Basic (which has $0 co-pays for all "preferred" providers, including

[40] *See*, e.g., The Official Website of the City of New York, NYC Health Benefits Program Summary of Benefits and Coverage (SBC), https://perma.cc/R9D8-LJ6E.

specialists);[41] Emblem HIP HMO Preferred ($0 co-pays for all "preferred" providers, including specialists, and $10 co-pays for "participating" specialists);[42] and MetroGold ($0 co-pays for all in-network providers, including specialists).[43] Thus, elderly and disabled Retirees will soon pay *more* in co-pays than their active employee counterparts. Not only is that a violation of the Moratorium Law, it is also deeply unfair given that Retirees generally require more frequent medical care and, because they live on fixed pensions which they cannot collectively bargain, are less able to absorb increased healthcare costs.

b. Prescription drug benefits

Retirees will also suffer a diminution of their prescription drug benefits under the Aetna MAP. Pizzitola Aff. at ¶ 33. Active employees, on the other hand, will face no comparable diminution. *Id*.

Under Senior Care, Retirees have had the option to buy either the GHI Enhanced Medicare Prescription Drug Plan ("Senior Care Drug Rider")[44] or a drug rider on the open market. *Id*. The premium for the Senior Care Drug Rider is $125 per month. *Id*. Many other plans on the open market are even less expensive, with monthly costs ranging from around $11 to $75. *See, e.g.*,

---

[41] *See,* e.g., The Official Website of the City of New York, EmblemHealth Summary of Benefits and Coverage - PPO, https://perma.cc/X544-68GW. Other co-pays for GHI-CBP, the plan that has always been the most popular among active employees, have increased by no more than $5-10 since the plan was first introduced decades ago. Pizzitola Aff. at ¶ 29 n.1.

[42] *See,* e.g., The Official Website of the City of New York, EmblemHealth Summary of Benefits and Coverage – HMO, https://perma.cc/748U-4N64.

[43] *See,* e.g., The Official Website of the City of New York, MetroPlus Gold Summary of Benefits and Coverage – HMO, https://perma.cc/C34P-E37D.

[44] *See,* e.g., EmblemHealth, Summary of Benefits – 2023 GHI Enhanced Medicare Prescription Drug Plan, https://perma.cc/ZLR4-LGMN.

Pizzitola Aff. at ¶ 33; Pizzitola Aff., Ex. 1 at Bollacke Aff. ¶ 5; *id.* at Carroll Aff. ¶ 11. Under the Aetna MAP, however, Retirees *must* buy the Aetna Medicare Rx offered by SilverScript ("Aetna SilverScript").[45] Retirees have no option to buy another drug rider on the open market. The Aetna SilverScript costs $135 per month, which is more expensive than the Senior Care Drug Rider and many other drug riders on the open market.

In addition, the cost of drugs under the Aetna SilverScript is substantially higher than the cost of drugs under the Senior Care Drug Rider and other drug riders on the open market. For instance, the cancer drug Jakafi costs several times as much—thousands of dollars more—under the Aetna SilverScript as compared to the Senior Care Drug Rider. *See, e.g.*, Pizzitola Aff., Ex. 1, at Namm Aff. ¶ 5; *see also, e.g.*, *id.* at Tortorici Aff. ¶ 9 (monthly cost of Phentermine will rise from $2.62 to $28.58 and cost of Trulicity will increase from $199.81 to $251.44); *id.* at Bollacke Aff. ¶ 5 (noting $682/month increase in drug coverage cost under Aetna MAP); *id.* at Abdale Aff. ¶ 9 (explaining that the cost of abiraterone acetate pills will increase from $1,300/month under Senior Care Drug plan to $2,329/month under Aetna SilverScript).

There has been no comparable increase in prescription drug costs for active employees. Pizzitola Aff. at ¶ 33. Moreover, the cost of prescription drug coverage will be cheaper for active employees than for Retirees. *Id.*

c. Elimination of healthcare choice and access to care

Retirees' healthcare benefits will also be disproportionately diminished through the elimination of their health insurance options. Retirees have always enjoyed a wide selection of

[45] *See*, e.g., Aetna Medicare, 2023 Summary of Benefits Aetna Medicare Rx offered by SilverScript Employer PDP sponsored by City of New York, 2023, https://perma.cc/6RS2-8JRT.

health insurance plans (usually around a dozen), including Medicare supplemental plans, which are accepted by virtually all medical providers. Pizzitola Aff. at ¶¶ 9-14, 17, 25, 31. Absent injunctive relief, they will now have only one option: the Aetna MAP, which many medical providers will not accept. Retirees who live in a few select counties in New York will also have the option of enrolling in HIP VIP, but that plan is unavailable to many Retirees and, in any case, it provides little additional value since it is just a more restrictive Medicare Advantage plan. Pizzitola Aff. at ¶ 25.

Because many medical providers will not accept the Aetna MAP, this lack of healthcare choice—and, specifically, the lack of a Medicare supplemental option—will make it difficult, if not impossible, for many Retirees to receive continued care from their doctors. *See, e.g.*, Archer Aff. at ¶ 8; Ryan Aff. at ¶¶ 26-30; Pizzitola Aff., Ex. 1. Active employees, by contrast, will continue to enjoy uninterrupted access to their doctors under the same roughly dozen health insurance options they have long had.[46] This disparity between active employees and Retirees is especially unfair because continuity of care is generally more important for Retirees, whose old age and disabilities make them particularly vulnerable. *See, e.g.*, Barrios-Paoli Aff. at ¶ 14.

Even apart from ensuring continuity of care, having a choice of multiple health insurance plans is inherently beneficial because it ensures access to a wider range of medical providers and healthcare benefits. Aetna itself made this point in recent litigation.[47] Different people have different needs, and a plan that works well for one might not work well for another. Barrios-Paoli

---

[46] *See*, e.g., The Official Website of the City of New York, NYC Health Benefits Program Summary of Benefits and Coverage (SBC), https://perma.cc/R9D8-LJ6E.

[47] *See Aetna Life Insurance Company v. Renee Campion et al* (Sup. Ct. N.Y. Cty.), Index No. 158216/2021, NYSCEF Doc. No. 6 at Ex. 5, p. 5; NYSCEF Doc. No. 16 at 5-6, ¶ 21 (arguing that deprivation of healthcare choice will irreparably harm Retirees).

Aff. at ¶¶ 10-12. Indeed, lawmakers passed Section 12-126 and its authorizing state statute in order to protect healthcare choice, with the goal being to "permit each [person] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances." Gardener Aff., Ex. H at 79. By providing this choice to employees but not to Retirees, the City is violating the Moratorium Law.

d. Prior authorization

The City will also be diminishing Retiree healthcare benefits by imposing onerous new prior authorization requirements. Under Medicare plus supplemental insurance, Retirees have always received care from their medical providers without needing the prior approval of an insurer. Under the Aetna MAP, they will need such approval for numerous services and medications. This is a major paradigm shift for Retirees. And it is a dangerous one too, as prior authorization protocols—particularly Aetna's—notoriously cause widespread denials of and delays in medical care. *See* Statement of Facts, Part B, *supra*. Because active employees will experience no corresponding diminution of their healthcare benefits, this is yet another violation of the Moratorium Law.

To be sure, health insurance plans for active employees have long required prior authorization for certain services. However, because active employees are generally healthier and more resilient than Retirees (who are all elderly or disabled), denials of and delays in their care are less likely to be fatal. *See, e.g.*, Omdahl Aff. at ¶ 36.

D. City Administrative Procedure Act

The sections above focused on three ways in which the City's new Retiree healthcare policy is substantively unlawful. As explained below, the policy was also adopted in a procedurally unlawfully manner, which provides an additional basis for an injunction.

This case involves a drastic change to the rules that have governed the City's Health Benefits Program for over half a century. Since the 1960s, the City has guaranteed Retirees free healthcare through a combination of Medicare plus a choice of Medicare supplemental plans. Pizzitola Aff. at ¶ 10. In March 2023, OLR issued an unprecedented order stripping Retirees of this health insurance and automatically enrolling them in a Medicare Advantage plan. *See* Gardener Aff., Ex. A. As discussed previously, Medicare Advantage is fundamentally different from Medicare plus supplemental insurance. *See RiseDelaware*, 2022 WL 11121549, at *2, 4 (granting preliminary injunction because a "Medicare Advantage plan is substantially different" from Medicare plus supplemental insurance).

The City's planned switch from Medicare to Medicare Advantage must be enjoined because it was not done in compliance with the City Administrative Procedure Act, N.Y.C. Charter, Ch. 45 ("CAPA"). CAPA provides a vital check on government power by protecting the right of ordinary citizens to review and weigh in on agency "rules" before they become bound by them. CAPA, § 1043. Every "rule" must undergo, among other things: (i) publication in the City Record with the "purpose of the proposed rule" and "the statutory authority" supporting it; (ii) a 30-day public notice-and-comment period; (iii) public hearings; and (iv) review by the Corporation Counsel and City Council. *Id*. The City did not even attempt to comply with these procedures here. Pizzitola Aff. at ¶¶ 44-46.

The City will presumably argue that it did not need to comply with CAPA because it did not adopt any rules. It would be wrong. A "rule" is defined broadly as "the whole or part of any statement or communication of general applicability that (i) implements or applies law or policy, or (ii) prescribes the procedural requirements of an agency including an amendment, suspension, or repeal of any such statement or communication." CAPA, § 1041(5).

"According to the Charter Revision Commission, CAPA's definition of a 'rule' is 'to be construed broadly to accommodate the act's basic objectives,'" which are to ensure government "accountability and openness." *Callahan v. Carey*, 2012 WL 680318 (Sup. Ct. N.Y. Cty. Feb. 21, 2012) (quoting 2 Report of NY City Charter Rev. Commn: Dec. 1986-Nov. 1988 ("Report"), at 86); *see also* Lane, *When Is a Rule a Rule?*, 3 City L 1, 6 (1997). Indeed, "the framers[] inten[ded] CAPA's provisions [to] be used generously" in light of the strong "legislative desire to give the citizenry a voice in the operation of government." *1700 York Assocs. v. Kaskel*, 182 Misc. 2d 586, 595 (Civ. Ct. N.Y. Cty. 1999) (quoting *Ass'n of Messenger Servs., Inc. v. City of New York*, 136 Misc. 2d 869, 875 (Sup. Ct. N.Y. Cty. 1987)).

The City's new Retiree healthcare policy satisfies this expansive definition of "rule" in at least two ways: OLR issued a "statement" of "general applicability" (it applies to all Retirees) that both (1) "implements" the City's new healthcare "policy" and also (2) purports to "apply" Section 12-126, the "law" governing Retiree healthcare benefits.[48] Thus, the plain text of the statute compels the conclusion that the City adopted a "rule." *Cole v. Mandell Food Stores, Inc.*, 93 N.Y.2d 34, 39 (1999) ("courts are obligated to construe [a] statute so as to give effect to the plain meaning of the words"). That conclusion is bolstered by the clear legislative command to construe the term "rule" broadly so as to ensure government transparency and accountability, which are especially important in this case where the healthcare rights of a quarter-million elderly and disabled Retirees are at stake.

[48] "The term 'general applicability' encompasses any statement or communication that applies similarly to members of a class, regardless of the number of members in any such class." Report at 86.

Lest there be any doubt about CAPA's applicability here, the City's conduct also happens to satisfy one of the very specific (non-exhaustive) examples of a "rule" mentioned in the statute. By conditioning the provision of health insurance benefits on a Retiree's enrollment in Medicare Advantage and compliance with the terms of such insurance, the City has set new "standards for the granting of . . . benefits." CAPA, § 1041(5)(a)(vii).[49]

Further, common sense confirms that the City is implementing new healthcare "rules." Under the City's new Retiree healthcare policy, for the first time in history: (1) Retirees will no longer be able to enroll in Medicare plus their choice of Medicare supplemental insurance; (2) instead, if they want free health insurance (as is their statutory right), they must enroll in a Medicare Advantage plan chosen by the City; (3) if Retirees wish to continue seeing medical providers who do not accept Medicare Advantage generally or the Aetna MAP specifically, they will have to pay for their own healthcare; (4) Retirees will be prohibited from obtaining services and medications subject to prior authorization unless Aetna first deems them medically necessary; (5) if Retirees wish to see out-of-network doctors, they will be responsible for ensuring that Aetna deems the services ordered by their doctors to be medically necessary and will be financially responsible for the cost of any services provided that are not deemed medically necessary; and (6) in-network medical providers treating Retirees will have to refrain from administering services subject to prior authorization unless and until Aetna deems them medically necessary. This is rulemaking, regardless of what the City might call it. *See 1700 York Assoc.*, 182 Misc.2d at 594

[49] CAPA also lists as an example of a "rule" the imposition of any "fee to be charged by or required to be paid to an agency." CAPA, § 1041(5)(a)(ii). That is analogous to what the City will be doing here by requiring Retirees to pay for their own Medicare supplemental insurance.

("An agency may not circumvent CAPA's rulemaking requirements by giving a different label to what is in purpose or effect a rule or amendment to a rule.").[50]

The Court of Appeals' decision in *Schwartfigure v. Hartnett*, 83 N.Y.2d 296 (1994), is instructive. In that case, the Department of Labor implemented a policy regarding the payment of unemployment benefits to individuals who were previously overpaid. The policy was to provide these individuals 50% of the unemployment benefits for which they were eligible and set off the remaining 50% to recover the previous overpayment. The Court of Appeals held that this constituted a "rule" for Administrative Procedure Act purposes because it involved a "policy invariably applied across-the-board to all claimants without regard to individualized circumstances or mitigating factors." 83 N.Y.2d at 301.[51] The same is true in the present case. OLR is implementing a rigid policy that will be applied across the board to all Retirees without regard to individualized circumstances or mitigating factors. Specifically, OLR will provide Retirees 100% of their health insurance if they switch to the City's Medicare Advantage plan and 0% if they wish to remain on Medicare plus supplemental insurance.[52]

---

[50] *See also Transp, Inc. v. Bd. of Educ. of New York City*, 1996 WL 34573240 (Sup. Ct. N.Y. Cty. Dec. 24, 1996) ("The label or name employed is not important and, unquestionably, many so called 'orders' come within the term."); Report at 85-86 ("The definition of a rule . . . is functional and requires compliance with rulemaking whenever pronouncements, intended to have the effects set forth, are made, whether they are called rules, regulations, orders or anything else.").

[51] Although *Schwartfigure* involved the State Administrative Procedure Act rather than CAPA, the two statutes contain the same definition of "rule" and are interpreted consistently. *Council of City of New York v. Dep't of Homeless Servs. of City of New York*, 22 N.Y.3d 150, 154 (2013).

[52] Courts routinely find similar across-the-board policies to be "rules." *See, e.g.*, *Kahrmann v. Crime Victims Bd.*, 14 Misc. 3d 545, 549 (Sup. Ct. Albany Cty. 2006) (policy that crime victims not be entitled to reimbursement for telephone counseling constituted a "rule"); *Council of City of New York*, 22 N.Y.3d at 153 (eligibility policy regarding temporary housing assistance constituted a "rule"); *HD Servs., LLC v. New York State Comptroller*, 51 A.D.3d 1236, 1237 (3d Dep't 2008)

Just last year, the Delaware Superior Court held that this *exact same* switch from Medicare plus supplemental insurance to Medicare Advantage constituted a rule under Delaware's analogous Administrative Procedure Act. *See RiseDelaware*, 2022 WL 11121549, at *3. Because Delaware—like the City here—failed to comply with the required statutory procedures before switching its retirees to a Medicare Advantage plan, the court enjoined it from making the switch and ordered it to continue covering retirees under their existing Medicare supplemental insurance. *Id*. at *5. Because the facts and the law are virtually identical here, the outcome should be as well.

Lastly, it is important to note that, just before OLR announced that the City would cease providing Medicare supplemental insurance, Mayor Adams spent months pushing for an amendment to Section 12-126 (the law governing Retiree healthcare benefits) that would have allowed the City to shift the cost of Medicare supplemental insurance onto Retirees. Pizzitola Aff. at ¶¶ 22-23. The City Council rejected that proposed legislation. *Id*. at ¶ 22. Instead of accepting this legislative defeat, the City has decided to make an illegal end-run around it by unilaterally forcing Retirees to find and pay for their own Medicare supplemental insurance. Not only is the City circumventing the legislative process, it is violating Retirees' procedural rights under CAPA.

The City presumably refused to comply with CAPA because it wanted to avoid the scrutiny, accountability, and public outcry such compliance would have entailed. The City preferred to control public opinion by falsely advertising the Aetna MAP as an "improve[ment]

(policy requiring notarization for abandoned property finder agreements constituted a "rule"); *Consumer Directed Pers. Assistance Ass'n of New York State v. Zucker*, 65 Misc. 3d 1005, 1010 (Sup. Ct. Albany Cty. 2019) (reimbursement policy for home care services constituted a "rule").

upon retirees' current plans" and "in the best interests of . . . our city's retirees."[53] Had the truth of the City's cruel healthcare policy been exposed to the harsh glare of CAPA's months-long notice and comment process, the backlash would have been overwhelming and could have forced City leaders to abandon—or at least substantially modify—the policy. Pizzitola Aff. at ¶ 45. A quarter-million Retirees were unlawfully deprived of this potential outcome and the right to have their voices heard before the rules governing their healthcare were upended.

In conclusion, the City's sweeping overhaul of Retiree healthcare squarely qualifies as a "rule" under CAPA's broad definition of that term, thus triggering the statute's procedural protections. Because the City indisputably did not follow these required procedures, its planned healthcare overhaul is invalid and must be enjoined. *Schwartfigure*, 83 N.Y.2d at 302.

E. Missing and Inaccurate Information

A year-and-a-half ago, this Court preliminarily enjoined the City from implementing its original Medicare Advantage plan because Retirees were being forced "to decide [whether to opt out of the plan] without adequate information." *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion,* No. 158815/2021, 2021 WL 4920705, at *2 (Sup. Ct. N.Y. Cty. Oct. 21, 2021). The same problem is happening again.

To begin with, many Retirees have not received either of the informational packages Aetna was supposed to send them. Pizzitola Aff. at ¶ 36. Many of these individuals are in their 80s and 90s and rely exclusively on hard-copy documents when making healthcare decisions. *Id.* They

---

[53] Office of the Mayor Press Release, March 30, 2023, https://www.nyc.gov/office-of-the-mayor/news/222-23/mayor-adams-olr-commissioner-campion-signing-medicare-advantage-contract#:~:text=NEW%20YORK%20%E2%80%93%20New%20York%20City,250%2C000%20retirees%20and%20their%20dependents.

are generally not online or using social media. *Id.* Because the packages contain basic information about the Aetna MAP, these individuals will be unable to make an informed enrollment decision.

Even Retirees who received the Aetna materials will be unable to make an informed enrollment decision because these materials misrepresent critical features of the Aetna MAP.

First, although the Aetna materials all promote the idea that Retirees will be able to keep their doctors if they enroll in the Aetna MAP (*see, e,g.*, Gardener Aff., Ex. K; *id.*, Ex. J), they do not warn Retirees that countless doctors, hospitals, and continuing care facilities are refusing to accept the plan. The materials urge Retirees to "**Switch your plan, not your doctors**," and claim that you can "**Keep your doctors**." Gardener Aff., Ex. J. But doctors are consistently telling Retirees they will not accept the Aetna MAP. Pizzitola Aff. at ¶¶ 17, 20; Pizzitola Aff., Ex. 1.

Second, the materials misrepresent the differences between the Aetna MAP and Retirees' existing Medicare plus supplemental insurance. Aetna's "Frequently Asked Questions" brochure poses the question, "What is different about this Aetna Medicare Advantage PPO plan compared to what I have now?" Gardener Aff., Ex. K. Amazingly, the listed answer *does not mention a single negative difference*. *Id*. It boasts that the Aetna MAP is "an all-in-one plan [that] simplif[ies] your health care" and provides "additional benefits" compared to Medicare. *Id*. But nowhere does it mention the limited provider network, the many doctors who will refuse to accept the plan, the dangerous prior authorization requirements, the increased costs, or the myriad other downsides. In response to another question, the brochure misleadingly states, "There are no penalties or higher cost shares if you see providers who are outside of the Aetna Medicare network." *Id*. That answer ignores the fact that out-of-network providers can choose to bill patients directly, Gardener Aff., Ex. D at 37-38, and that patients of out-of-network providers are

responsible for the entire cost of services later deemed medically unnecessary by Aetna, Gardener Aff., Ex. C at § 12.

Third, Aetna's brochure about prior authorization—a process that is foreign to most Retirees—completely misrepresents prior authorization. The brochure begins with the lie that prior authorization is "needed" to "Keep you safe" and "Keep your costs down." Gardener Aff., Ex. L. It then proceeds to assure Retirees that "If your doctor thinks you need a service or medicine that requires prior authorization, they'll let us know. . . . You do not have to do anything; your doctor will manage this process." *Id*. That is a dangerous misrepresentation: out-of-network doctors have no obligation to obtain prior authorization; and if they do not seek it (which many likely will not), Retirees will have to pay the entire cost of any service or medicine that Aetna later deems medically unnecessary. Gardener Aff., Ex. D at § 2.3. The brochure glosses over this frightening scenario, as well as the well-documented health risks posed by prior authorization requirements. Other Aetna materials do the same.[54]

Aetna's informational materials are rife with other misrepresentations and omissions that prevent Retirees from making an informed enrollment decision.

Finally, for Retirees who wish to maintain Medicare plus supplemental insurance, the City has made the process of opting out of the Aetna MAP utterly confusing and technically challenging, particularly for senior citizens. Aetna's informational materials state that Retirees who "do not want to enroll in" the Aetna MAP must "opt out" between May 1 and June 30. Gardener Aff., Ex. K. A number of Retirees have already tried opting out using the website listed

---

[54] *See, e.g.,* Gardener Aff., Ex. K (stating that Retirees "should encourage out-of-network providers to contact Aetna to ensure services are medically necessary or covered by Medicare," but failing to note the severe consequences of failing to do so).

in the informational materials, but, due to a technical glitch, they get an error message during the process. Pizzitola Aff., Ex. 37. Even if they could opt out, that would apparently not solve the problem. That is because, buried in an obscure OLR webpage, it states that anyone "opting out of the Aetna Medicare Advantage PPO Plan . . . will automatically be enrolled in HIP VIP."[55] Thus, *opting out of the Aetna MAP will just cause Retirees to be enrolled in HIP VIP*, another Medicare Advantage plan, which is only available in a few select New York counties. In order to avoid being forced against their will into a Medicare Advantage plan, Retirees must apparently *waive* City health coverage, either in addition to or in lieu of opting out. Confusingly, the OLR webpage communicates this by saying that "Retirees who do not wish to be enrolled in the Aetna Medicare Advantage PPO Plan or HIP VIP <u>can</u> waive City health coverage" by completing a special waiver form.[56] (emphasis added). By using the word "can" instead of "must," the webpage suggests that waiver is optional, when in fact it appears to be mandatory. The waiver form compounds the confusion by stating in bold at the top: "This is <u>not</u> an Opt-out Form."[57]

Thousands of elderly Retirees are hopelessly confused by all of this and frightened that they will make a mistake. Pizzitola Aff. at ¶ 37. They do not know whether they need to complete an opt-out form, a waiver form, or both. *Id.*

In conclusion, even if this Court does not enjoin the City's new healthcare policy pending a decision on the merits, it should at least stay its implementation until the City provides every

---

[55] New York City Office of Labor Relations, *Aetna Medicare Advantage PPO Plan*, https://perma.cc/AP89-HZG5.

[56] *Id*. (emphasis added).

[57] New York City Office of Labor Relations, Retiree Special Enrollment/Waiver Form, https://perma.cc/6JSV-WWPL.

impacted Retiree clear, accurate, and complete information about the Aetna MAP and the opt-out/waiver process. Forcing Retirees to make a monumental decision about their healthcare future without this information is arbitrary, capricious, and an abuse of discretion.

II. RETIREES WILL SUFFER IRREPARABLE HARM ABSENT A PRELIMINARY INJUNCTION

The City is forcing all Retirees to make the following choice by June 30: (1) let the City automatically enroll them in the Aetna MAP; or (2) opt out and pay several thousand dollars a year for a Medicare supplemental plan on the open market (unless they do not pass underwriting, in which case they will be uninsured) plus approximately $2,000 a year for the Medicare Part B premium.[58] As explained below, both options entail irreparable harm.

A. Enrolling in the Aetna MAP will Cause Irreparable Harm

Those who are automatically enrolled in the Aetna MAP will experience a number of adverse changes to their healthcare, each of which poses a serious threat of irreparable harm.

First, in contrast to Medicare plus supplemental insurance—which is accepted by virtually all doctors and hospitals around the country—a large number of medical providers do not accept Medicare Advantage plans in general or the Aetna MAP specifically. Archer Aff. at ¶ 9; Barrios-Paoli Aff. at ¶¶ 13, 37, 39; Burns Aff. at ¶ 7-10; Ryan Aff. at ¶ 13; Pizzitola Aff., Ex. 1. For those Retirees who are enrolled in the Aetna MAP, but whose doctors or hospitals refuse to accept it, they will have to scramble to switch medical providers. This will be incredibly disruptive and dangerous, particularly for those in the middle of a course of treatment for cancer or other life-

---

[58] Retirees who live in the City or a few surrounding counties also have the option of enrolling in HIP VIP, an existing Medicare Advantage plan with a very small provider network, which Retirees must stay within. This plan is unavailable to many Retirees and, in any case, suffers from the same defects common to Medicare Advantage plans.

threatening illness. Barrios-Paoli Aff. at ¶¶ 13-14, 18, 35, 47; Burns Aff. at ¶ 5; Omdahl Aff. at ¶ 36; Archer Aff. at ¶¶ 7, 10.

Such disruption to the continuity of care is a quintessential example of irreparable harm. In fact, the mere *threat* of such disruption is widely considered to be irreparable. For example, in *Plattsburgh City Retirees' Ass'n v. City of Plattsburgh*, the court granted a preliminary injunction to Medicare-eligible retirees because their "change in coverage [from one health insurance plan to another] *may* necessitate a change in healthcare providers and a change in course of treatment." 2016 WL 1424371, at *5 (Sup. Ct. Clinton Cty. 2016) (emphasis added). Similarly, in *Matter of Sheriff Officers Ass'n, Inc. v. Nassau County*, the court granted a preliminary injunction because "monetary damages are an inadequate substitute for the anticipated disruption in the continuity of medical care that *may* result" from a change in health insurance. 2012 WL 2367795, at *4 (Sup. Ct. Nassau Cty. 2012) (emphasis added). *See also Int'l Union of Operating Engineers, Loc. No. 463 v. City of Niagara Falls*, 191 Misc. 2d 375, 380 (Sup. Ct. Niagara Cty.), *aff'd*, 298 A.D.2d 1010 (4th Dep't 2002) (finding irreparable harm because "changing a health care provider *may* require a change in physicians and a course of treatment" (emphasis added)); *Freeport Police Benev. Ass'n v. The Incorporated Village of Freeport*, 2012 WL 1642709 (Sup. Ct. Nassau Cty. Apr. 20, 2012) (granting preliminary injunction because "monetary damages are a weak substitute for the anticipated disruption in the continuity of medical care that *may* result from the implementation of" a new healthcare plan (emphasis added)).

Second, many Retirees live in continuing care facilities that will not house patients who have Medicare Advantage. *See, e.g.*, Archer Aff. at ¶ 14; Potter Aff. at ¶ 15; Miller Aff. at ¶ 4, 6-7; Pizzitola Aff. at ¶ 20; Pizzitola Aff., Ex. 1 at Forbes-Wolfe Aff. ¶¶ 4, 9. Even if those Retirees were at facilities that accepted Medicare Advantage, Aetna will not cover this expense unless it

deems it "medically necessary," Gardener Aff., Ex. C at § 12, which insurers frequently do not.[59] Thus, for Retirees residing in continuing care facilities, if they are forced into the Aetna MAP, they could lose not only medical care, but also their home. "It is well established that the loss of one's long-term home constitutes irreparable harm." *Bass v. WV Pres. Partners, LLC*, 209 A.D.3d 480, 482 (1st Dep't 2022)); *see also Suffolk Cty. Ass'n of Mun. Emps., Inc. v. Cty. of Suffolk*, 163 A.D.2d 469, 474 (2d Dep't 1990) (finding irreparable harm based on plaintiffs' potential loss of housing).

Third, because of the Aetna MAP's prior authorization requirements, Retirees will not be able to obtain various medical services and medications ordered by their doctors unless and until Aetna deems them medically necessary. Countless studies, including one recently conducted by HHS, have demonstrated that such prior authorization requirements cause widespread, life-threatening denials of and delays in medical treatment.[60] Indeed, the HHS Report noted "millions of denials each year," which are so routine and unwarranted that 75% of denials that are appealed eventually get reversed (thus causing extreme delays in care).[61] In a recent survey conducted by the American Medical Association, 94% of physicians reported that prior authorization requirements caused delays in necessary treatment, and, as a result, 33% reported "serious adverse

[59] *See* HHS Report at 14, 16.

[60] *See* HHS Report (detailing the "widespread and persistent problems related to inappropriate denials of services and payment" caused by Medicare Advantage prior authorization requirements); *see also, e.g.*, Maya Kaufman and Natalie Sachmech, *Rising denial rates impeding Medicare Advantage enrollees' access to inpatient rehab, providers say*, CRAIN'S, May 23, 2022, https://perma.cc/KSD8-YG5X (discussing how unjustified denials of coverage occur on a regular basis due to the prior authorization requirements imposed by Medicare Advantage plans).

[61] *See* HHS Report at 2, 9.

event[s]" that required medical intervention, 19% reported a life-threatening event, and 9% reported a serious disability or permanent bodily damage.[62]

Importantly, Aetna has been found to be the *worst* offender in the country when it comes to unwarranted denials of care. It has the *highest* prior authorization denial rate (12%)—which is *twice* the national average (6%)—as well as the *highest* rate of appeals (20%) and *second-highest* rate of denials having to be overturned on appeal (90%).[63] Indeed, as noted earlier, an Aetna medical director recently admitted under oath that he never looked at patients' records when deciding to deny care.

Thus, Retirees enrolled in the Aetna MAP face a significant risk of medical care being denied or delayed. Barrios-Paoli Aff. at ¶¶ 15-18; Burns Aff. at ¶¶ 11-12; Omdahl Aff. at ¶ 36. Courts "routinely" find irreparable harm where, as here, there is a risk of "delay in or inability to obtain medical services." *Wilson v. Gordon*, 822 F.3d 934, 958 (6th Cir. 2016) (collecting cases); *see also Mamula v. Satralloy, Inc.*, 578 F. Supp. 563, 577 (S.D. Ohio 1983) (holding that "delay in obtaining medical attention or [] not receiving any medical attention" constitute irreparable harm); *Strouchler v. Shah*, 891 F. Supp. 2d 504, 522 (S.D.N.Y. 2012) (holding that "the mere *threat* of a loss of medical care, even if never realized, constitutes irreparable harm" (emphasis in original)).

Fourth, Retirees enrolled in the Aetna MAP will encounter a host of new, unprecedented costs most cannot afford and none expected. For instance, if a Retiree is receiving treatment from a medical provider that will not accept the Aetna MAP, the Retiree may have to cover the cost

---

[62] *See* 2022 AMA Prior Authorization Physician Survey, https://perma.cc/U2YU-8DGA.

[63] *See* KFF Report (comparing data on Aetna (CVS) and other Medicare Advantage insurers).

herself, which could be several thousand dollars per treatment.[64] Gardener Aff., Ex. M at 2; *id.*, Ex. D at 37-38; *id.*, Ex. K; Pizzitola Aff. at ¶ 48. Likewise, if a Retiree is treated by an out-of-network doctor, and Aetna later deems that treatment medically unnecessary, that Retiree will be on the hook for the entire cost of the treatment, which, again, could be thousands of dollars. Pizzitola Aff. at ¶ 49; Gardener Aff., Ex. D at 20-21. Further, under the Aetna MAP, Retirees will have to pay a $15 co-pay for various medical services (as compared to $0 under their current plan). Pizzitola Aff. at ¶¶ 29, 50; Gardener Aff., Exs. C, D. For those with chronic medical conditions, this can add up to hundreds, or even thousands, of dollars a year. In addition, Retirees face significantly higher prescription medication costs under the Aetna MAP, which will result in hundreds, or even thousands, of dollars in added expenses for many. *See* Part I(C)(iii)(d), *supra*; *see also* Pizzitola Aff. at ¶ 33; Pizzitola Aff., Ex. 1 at Bollacke Aff. ¶ 5; *id.* at Carroll Aff. ¶ 11.

Because most Retirees are struggling to survive on their small, fixed incomes—tens of thousands of which are less than $1,500 a month—and must receive treatment on a regular basis due to their advanced age and/or disabilities, they generally cannot afford hundreds—let alone thousands—of dollars in new healthcare costs, particularly those they never anticipated. Pizzitola Aff. at ¶¶ 8, 52; Barrios-Paoli Aff. at ¶¶ 47-49. As a result, they will either have to forego needed medical care or reduce spending on other necessities (such as medicine, food, heat, transportation, etc.), both of which constitute irreparable harm. Pizzitola Aff. at ¶ 52; Pizzitola Aff., Ex. 1. *See, e.g., Civ. Serv. Emps. Ass'n, Inc., Loc. 1000, AFSCME, AFL-CIO v. New York State (Unified Ct. Sys.)*, 73 Misc. 3d 874, 895 (Sup. Ct. Albany Cty. 2021) (holding that irreparable harm exists when

[64] Even if Aetna decides to reimburse the Retiree for some or all of that amount following a prolonged reimbursement request process, that is little comfort to the scores of Retirees who cannot afford to lay out thousands of dollars in the hope that they will eventually be reimbursed.

individuals are forced to "forgo medical treatment"); *LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48, 55 (2d Cir. 2004) (holding that increased out-of-pocket insurance costs that threatened retirees' "[]ability to purchase life's necessities" caused irreparable harm); *Golden v. Kelsey-Hayes Co.*, 845 F. Supp. 410, 415 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996) (finding irreparable harm because retirees "may be forced to forgo needed medical care" or other "basic necessities" due to increased monthly medical costs as low as $21); *Merkner v. AK Steel Corp.*, 2010 WL 373998, at *5 (S.D. Ohio Jan. 29, 2010) (finding irreparable harm because increased monthly healthcare costs of as little as $61 would cause retirees to forego medical care or "ration[]" the "necessities of life"); *United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d. 6, 8 (1st Cir. 1987) (explaining that courts have consistently found irreparable harm where retirees must pay for healthcare expenses "out of money that they need for other necessities of life"); *Schalk v. Teledyne, Inc.*, 751 F. Supp. 1261, 1267–68 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991) (finding irreparable harm because co-pays and other out-of-pocket costs as low as $180 a year "might" cause retirees "to forego necessary medical treatment"); *Angotti v. Rexam, Inc.*, 2006 WL 1646135, at *15 (N.D. Cal. June 14, 2006) (finding irreparable harm based on retirees' "anticipat[ion] that they will have to postpone or forego" medical care due to cost concerns); *Olson v. Wing*, 281 F. Supp. 2d 476, 486 (E.D.N.Y.), *aff'd*, 66 F. App'x 275 (2d Cir. 2003) (holding that irreparable harm occurs whenever one is "forced by circumstances to forego treatment or medication"); *Zotto v. Scovill, Inc.*, 1985 WL 14176, at *2 (D. Conn. Nov. 7, 1985) (finding irreparable harm because retirees might "forego needed medical treatment if they were required to pay for it"); *Becker v. Toia*, 439 F. Supp. 324, 336 (S.D.N.Y. 1977) (holding that minor increase in healthcare costs would cause irreparable harm to plaintiffs who would not be able to afford medication).

This Court recently held that a $15 co-pay on medical services constituted irreparable harm to this very group of Retirees based on this very risk of foregone care and other necessities. *Bianculli*, 2023 WL 158773, at *2. That holding was unanimously affirmed by the First Department last week. *See Bianculli v. City of New York Office of Labor Relations*, 2023 WL 3633367 (1st Dep't May 25, 2023).

B. Opting out of the Aetna MAP will Cause Irreparable Harm

As described in the attached affidavits, many Retirees will have to opt out of the Aetna MAP in order to keep their doctors and avoid dangerous prior authorization requirements. Opting out of the Aetna MAP presents its own distinct, and potentially more extreme, threat of irreparable harm.

First, under the City's new healthcare rules, any Retiree who opts out of the Aetna MAP must pay the entire cost of their own health insurance. *See* Gardener Aff., Ex. A; Pizzitola Aff., ¶ 26. That includes Medicare Part B, which costs approximately $2,000 a year,[65] and Medicare supplemental insurance, which costs several thousand dollars a year. *See, e.g.*, Barrios-Paoli Aff. at ¶¶ 32, 47-49.

As discussed above and as demonstrated a few months ago in the Retirees' co-pay class action, virtually no Medicare-eligible retired City worker can afford to pay several thousand dollars a year (the equivalent of several months' pension for most) without dramatically reducing their spending on necessities such as medicine, food, housing, utilities, and transportation. Pizzitola Aff. at ¶ 52. And as discussed in the previous subsection, that is a universally recognized form of irreparable harm.

[65] *See* Centers for Medicare & Medicaid Services, https://perma.cc/9X4S-Z2KV.

Second, in virtually all of the states where Retirees live, individuals with serious medical problems can be, and regularly are, denied Medicare supplemental coverage due to their preexisting conditions. Archer Aff. at ¶ 15; Burns Aff. at ¶ 22; Barrios-Paoli Aff. at ¶ 40; Omdahl Aff. at ¶ 91.[66] In addition, in many states, those who are under 65 and Medicare-eligible due to disability may be unable to access a Medicare supplemental plan at all on the open market. Burns Aff. at ¶ 17, 21-23; Omdahl Aff. at ¶¶ 88-89, 91; Barrios-Paoli Aff. at ¶ 40. Thus, many Retirees who opt out of the Aetna MAP in order to pursue Medicare supplemental insurance will be denied coverage. Such loss of health insurance coverage is a widely recognized form of irreparable harm. *See, e.g.*, *Int'l Union of Operating Engineers*, 191 Misc. 2d at 380 (holding that loss of health insurance coverage constitutes irreparable harm); *Commc'ns Workers of Am., Dist. One, AFL-CIO v. NYNEX Corp.*, 898 F.2d 887, 891 (2d Cir. 1990) (holding that "denial of medical coverage" constitutes irreparable harm); *Whelan v. Colgan*, 602 F.2d 1060, 1062 (2d Cir. 1979) (holding that the mere "threatened termination of benefits such as medical coverage for workers and their families obviously" poses threat of irreparable harm).

C. Retirees will Suffer Additional Irreparable Harm Regardless of their Enrollment Decision

Regardless of whether Retirees enroll in or opt out of the Aetna MAP, they face two other well-recognized forms of irreparable harm.

First, all Retirees will be irreparably harmed by the violation of their procedural rights under CAPA if the City is allowed to proceed with its new healthcare policy. Where, as here, members of the public are denied a statutorily protected opportunity to review or comment on

---

[66] Those who are lucky enough to obtain coverage at all will be charged a fortune due to the extraordinary insurance risk they present. Barrios-Paoli Aff. at ¶¶ 32, 47; Omdahl Aff. at ¶¶ 83, 92; Burns Aff. at ¶ 23.

proposed agency action before it is implemented, the harm they suffer is per se irreparable. *See, e.g., RiseDelaware*, 2022 WL 11121549, at *4 ("[T]his Court recognizes irreparable harm in Plaintiffs and other retirees being denied a statutorily protected right to review or comment on proposed agency action [switching them to Medicare Advantage] before its implementation."); *Louisiana v. Horseracing Integrity & Safety Auth. Inc.*, 2022 WL 2960031, at *13 (W.D. La.) (holding that the "alleged violations of the APA, which did not allow sufficient time for public comments, constitute irreparable injury"); *Texas v. Becerra*, 577 F. Supp. 3d 527, 559 (N.D. Tex. 2021) (holding that party suffers "irreparable injury by being denied its procedural right [under the APA] to comment on the Rule"); *Alaska v. Lubchenco*, 2012 WL 13035040, at *2–3 (D. Alaska), *aff'd*, 723 F.3d 1043 (9th Cir. 2013) (holding that defendant's failure to "provide the public with a sufficient opportunity for review and comment on the [environmental assessment] . . . caused irreparable harm to the Plaintiffs' and the public's procedural rights").

Had the City's 250,000 Retirees been given the statutorily required notice and opportunity to review and comment on the City's new healthcare policy before it was adopted, large numbers would have vehemently objected at public hearings and submitted written materials explaining why the proposed policy was cruel and unfair, and how alternative policies could achieve comparable savings. Pizzitola Aff. at ¶ 45. City officials, in turn, would have been required to consider this input and publicly justify any decision to move forward with implementation. This process might have created enough outrage and political pressure to force City leaders to abandon—or at least substantially modify—the policy. *Id*. Absent a preliminary injunction, we will never know.

Second, as reflected in the attached affidavits, if the City's unlawful healthcare overhaul is allowed to proceed, countless elderly and disabled Retirees will continue to experience crippling

anxiety over the potential disruption to their medical care and finances. *See* Pizzitola Aff., Ex. 1. Such stress poses heightened risks to senior citizens, particularly those with compromised health. Courts routinely hold that retirees' anxiety about major changes to their healthcare qualifies as irreparable harm. *See, e.g.*, *LaForest*, 376 F.3d at 55 (holding that retirees' "anxiety" over "uncertainty" associated with healthcare changes constituted irreparable harm); *Textron*, 836 F.2d at 8 (finding irreparable harm where "retired workers would likely suffer emotional distress" regarding changes to their healthcare); *Schalk*, 751 F. Supp. at 1268 (finding irreparable harm based on retirees' financial and medical "uncertainty"); *Angotti*, 2006 WL 1646135, at *16 (finding irreparable harm based on the "reasonabl[e] infer[ence] that all or virtually all retirees will be faced with some increased financial anxiety"); *Merkner*, 2010 WL 373998, at *5 (finding irreparable harm due to retirees' "increased uncertainty and anxiety" relating to increased healthcare costs); *Thrower v. Perales*, 138 Misc. 2d 172, 178 (Sup. Ct. N.Y. Cty. 1987) (finding irreparable harm based on "psychological hardship" faced by those in dire financial circumstances).

The stories of Retirees in the final years of their lives panicking (justifiably) over this drastic change to their healthcare—the one thing they relied on to remain stable—are heartbreaking. Consider the example of Mary Nevins, who is in the process of divorcing her abusive spouse after a prolonged period of domestic violence. Pizzitola Aff., Ex. 1 at Nevins Aff. Due to her medical circumstances, she needs Medicare plus supplemental insurance, but she cannot afford to pay the several thousand dollars a year it would cost. *Id.* at ¶¶ 9-14. As a result, if the City is allowed to force her into the Aetna MAP, she will have to halt divorce proceedings and reengage with her abuser—with whom she has had no contact—in order to obtain insurance through his employer. *Id.* at ¶¶ 4-6, 12, 15. Although this is a terrifying proposition for her, it is

less terrifying than losing her healthcare benefits. Ms. Nevins's story reflects the desperation felt by the entire Retiree community.

III. THE BALANCE OF EQUITIES WEIGHS HEAVILY IN THE RETIREES' FAVOR

The equities overwhelmingly favor the Retirees. Absent injunctive relief, a quarter of a million elderly and disabled individuals will be stripped of critical healthcare benefits they were promised throughout their lives. Many will be forced to switch healthcare providers, leave the continuing care facilities where they have lived for years, incur medical costs they cannot afford, and/or forego needed medical care and other necessities. They will also be denied procedural rights guaranteed under CAPA.

By contrast, granting temporary injunctive relief would simply maintain a status quo that has existed uninterrupted for nearly 60 years. Indeed, since the 1960s, the City has always offered, and paid for, Medicare plus multiple Medicare supplemental plans. Given the life-or-death consequences here for Retirees, and the City's historic budget surplus,[67] the City can easily wait for a decision on the merits before implementing its new healthcare policy.

It is well-settled that the health and well-being of elderly and disabled individuals far outweigh any potential monetary loss to the government. *See, e.g., Plattsburgh City Retirees' Ass'n v. City of Plattsburgh*, 51 Misc. 3d 1209(A), at *5 (Sup. Ct. Clinton Cty. 2016) (holding that a "loss of or reduction in health care coverage outweighs any possible monetary loss to the City"); *Thrower*, 138 Misc. 2d at 178 (finding that equities favored plaintiffs because "[t]heir physical and

[67] The City has the highest cash reserves in history, including a $4.9 billion surplus on a budget of over $100 billion. *See Testimony of the New York City Independent Budget Office*, March 6, 2023, https://perma.cc/9T74-CKPL; Citizens Budget Commission, *Big Budget, NYC's Adopted FY 2023 Budget – Spending and Growth*, Jun. 28, 2022, https://perma.cc/PC9Z-U8Y2.

emotional suffering is far more compelling than the possibility of some administrative inconvenience or monetary loss to the government"); *Warshaw v. Jacobs*, 16 Misc. 2d 844, 846–47 (Sup. Ct. Queens Cty. 1959) (holding that "[m]ore important than property and profit rights are the health and welfare of the public," and that "[t]here is no balance of equities when public health and welfare are at stake"); *Becker*, 439 F. Supp. at 336 (holding that harm to Medicaid beneficiaries caused by imposition of co-pays "clearly" outweighed "the State's financial difficulties").

It is important to note that the City is prepared for (if not expecting) a preliminary injunction here, which is not surprising given that this Court granted such relief in the Retirees' two previous lawsuits against the City.[68] Knowing that the Retirees would again be challenging the City's attempt to force them into a Medicare Advantage plan, and anticipating that the Retirees would again prevail, the City specifically contracted for this likely event. The City's contract with Aetna contains a contingency plan for "the issuance of a temporary restraining order, injunction, or other federal or state court order" that requires the City to continue offering Retirees Medicare supplemental insurance. Gardener Aff., Ex. C at §§ 2.1, 2.3; *see also id.*, Ex. C at Attachment B: Medicare Advantage and Part D Rate Summary. And the City's contracts with Medicare supplemental insurance providers remain in effect. Pizzitola Aff. at ¶ 54. Thus, the City cannot claim here—as it did in the Retirees' previous two lawsuits—that a preliminary injunction would cause an undue burden, as it can easily continue covering Retirees under their existing health insurance during the pendency of this litigation.

---

[68] *See Campion*, No. 158815/2021, 2021 WL 4920705, at *2 (preliminarily enjoining the City from implementing its original Medicare Advantage plan); *Bianculli*, No. 160234/2022, 2023 WL 158773, at *3 (preliminarily enjoining the City from imposing co-pays on Retirees).

CONCLUSION

For the foregoing reasons, this Court should grant Petitioners' motion and temporarily enjoin the City from: (1) forcing Retirees off of their existing health insurance; and (2) enforcing its June 30 deadline to opt out of the Aetna MAP.

Dated: May 31, 2023
New York, NY

WALDEN MACHT & HARAN LLP

By:

Jacob Gardener
Hannah Belitz
250 Vesey St., 27th Floor
New York, NY 10281
(212) 335-2965
jgardener@wmhlaw.com

POLLOCK COHEN LLP
Steve Cohen
60 Broad St., 24th Floor
New York, NY 10004
(212) 337-5361
SCohen@PollockCohen.com

Counsel for Petitioners-Plaintiffs