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New York Supreme Court
Appellate Division: First Department

In the Matter of the Application of

Case No. 2022-01006

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

Petitioners-Respondents,

against

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

Respondents-Appellants.

REPLY BRIEF

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September 16, 2022

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PRELIMINARY STATEMENT

Much has changed since the City filed its opening brief here. After petitioners successfully delayed this appeal for months, the provider of the original Medicare Advantage plan at issue backed out. With any challenge to that particular plan moot, petitioners withdrew their cross-appeal, leaving only the City's challenge to Supreme Court's interpretation of Administrative Code § 12-126.

The permanent injunction based on that mistaken interpretation continues to constrain the City, hampering the ability to implement a new Medicare Advantage plan to achieve much-needed annual savings while providing retirees with premium-free, high-quality healthcare. And because the City continues to lose roughly $50 million every month it is enjoined, the City and municipal unions are exploring all options, including potential legislative steps, to remove the hurdle to these savings expeditiously.

The bottom line for the purpose of the City's appeal, however, is that petitioners have identified no reason why the current Administrative Code § 12-126 should stand in the way of the City's efforts to provide first-rate healthcare while saving the

City's taxpayers hundreds of millions of dollars. Indeed, petitioners do not even offer a coherent interpretation of the provision, preferring to peddle in mischaracterizations about the now-defunct plan and Medicare Advantage plans generally. They ignore that those plans cover nearly half of the nation's Medicare-eligible population, including many State and City employees.[1] Their characterizations are not just misplaced—Medicare Advantage plans can provide top-tier healthcare while achieving substantial savings—but also irrelevant to the interpretation of § 12-126.

Section 12-126 permits the City the flexibility to respond to the mounting fiscal challenges from steadily increasing healthcare costs, including by looking to the federal government to shoulder some of the burden. In petitioners' zeal to retain their current healthcare plan at zero cost, they mischaracterize § 12-126's text and legislative history, as well as the City's position in this and

[1] Meredith Freed & Jeannie Fuglesten Biniek, *Medicare Advantage in 2022: Enrollment Update and Key Trends*, Kaiser Family Foundation (Aug. 25, 2022), https://perma.cc/CS8B-2UVQ.

other litigation. And fundamentally, petitioners ignore the harm that their interpretation of § 12-126 would cause, not only to the City's ability to address spiraling healthcare costs but also to the healthcare options of the very retirees they claim to represent.

And even if this Court were to accept petitioners' claim that § 12-126 requires the City to pay for more than one plan, they cannot justify a statutory cap for Medicare-eligible enrollees that is tied to the enormously higher rate applicable to enrollees who are not eligible for Medicare. The City Council did not intend such an illogical result.

ARGUMENT

THE COURT SHOULD REJECT PETITIONERS' INTERPRETATION OF ADMINISTRATIVE CODE § 12-126

A. Nothing in petitioners' brief demonstrates a right to more than one free healthcare option.

Administrative Code § 12-126(b)(1) provides that "[t]he city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents," subject to a defined statutory cap. As our opening brief explained, that command is both significant and targeted: the City must make one premium-

free healthcare plan available to each category of insured—with the City's monetary obligation capped at a level tied to the relevant category of insurance. And the City can satisfy this command as to the only category at issue in this litigation, Medicare-eligible retirees, by making a new plan available to them at zero cost. Nothing in § 12-126 gives retirees a right to choose from a menu of several premium-free healthcare plans, much less a right to a particular plan of their preference.

Section 12-126's legislative history confirms the point. Deliberately rejecting language that would have required the City to pay for a "choice" of plans (Record on Appeal ("R") 1342), the City Council recognized that the City needs flexibility to craft and adapt its healthcare offerings to employees, retirees, and dependents to secure top-tier healthcare coverage while also achieving taxpayer savings and adjusting to ever-evolving fiscal and market conditions.

Petitioners offer no coherent response to this clear design. At times, they echo the lower court's misguided view that the City would satisfy § 12-126 by offering *one* premium-free plan, but that

if the City instead allows people to decline that plan and enroll in other plans at their election, the law requires it to pay for those *other* plans too (Brief for Respondents ("Resp. Br.") 6, 28, 30–32, 35–38, 43 (statute requires payment only for "offered" or "available" plan)). At other times, petitioners pivot to what seems to be their true position, arguing that § 12-126 requires the City to pay for retirees' "choice of health insurance" (Resp. Br. 3, 35; *see also id.* at 6 (statute requires payment for "retirees' existing health insurance"); *id.* at 41–42 (statute requires paying for "any and all" plans); *id.* at 48–49 ("limit[ing]" options "violate[s]" statute's purpose)).

But at the end of the day, petitioners never offer an interpretation of § 12-126 that delivers on their claim that retirees have a statutory right to choose from a menu of premium-free healthcare options. When petitioners get to the statutory text—on page 37 of their brief—they hang their hat on the fact that certain ancillary terms appear in the plural, and on that foundation contend that § 12-126 compels the City to offer *multiple* healthcare plans.

While the premise is mistaken (*see infra* at 10), the more fundamental point is that even under petitioners' reading of the text, § 12-126 would be satisfied if the City were to provide just *two* premium-free plans—such as one premium-free plan for active employees and one for retirees. Nowhere do petitioners articulate how § 12-126 could possibly be read to compel the City to offer *several* premium-free plans to each category of insured, with enough diversity among them, to generate an undefined range of "choice of health insurance" (Resp. Br. 3). That is because neither the statute's text, its legislative history, nor commonsense support petitioners' view.

1. Section 12-126's text does not support petitioners' implausible reading.

Petitioners' textual analysis does not hold water. Notably, petitioners offer no defense for Supreme Court's assertion that § 12-126's language that the City "will pay" for "health insurance coverage" implies an obligation to pay for all plans offered (R9; Brief for Appellants ("City Br.") 29–30). Instead, § 12-126 requires the City to pay for only "[a] program of hospital-surgical-medical

benefits," which is satisfied by offering retirees a completely premium-free healthcare plan (City Br. 30–33).

Nor do petitioners dispute that the local law is compatible with certain types of opt-outs: they seem to accept that it does not require the City to pay even when employees decline city coverage altogether, in favor of being covered as a dependent on a partner's healthcare plan. Yet they contend that the law bars the City from offering individuals a somewhat different opt-out: the ability to decline a designated premium-free plan in favor of a different plan that they must agree to pay for themselves. They do so even though such options can substantially benefit enrollees, given the City's ample bargaining power to negotiate favorable plan terms.

Petitioners hinge their textual argument, such as it is, on the claim that the term "health insurance coverage" implies a "broad[]" obligation to pay for more than one plan for each category of insured (Resp. Br. 37). But nothing about the term "coverage" implies a requirement to pay for multiple plans for every category of insured; indeed, the City provides "coverage" for each retiree by making *one* premium-free plan available to them, and § 12-126

contains no mandate as to whether that plan must be Senior Care, a Medicare Advantage plan, or anything else.

And contrary to petitioners' claim (Resp. Br. 37), the use of the term "health insurance plan" elsewhere in the law only confirms the singular meaning of the term "health insurance coverage." The local law uses the two phrases interchangeably. For example, the law provides that if certain deceased uniformed officers were enrolled in a "health insurance plan," their surviving spouses were entitled to "such health insurance coverage" (as well as "health insurance coverage" predicated on Medicare) provided they paid 102% of the group rate for "such coverage." § 12-126(b)(2)(ii)–(iv). And a surviving spouse who elects "such coverage" is similarly paying for only one plan, not a menu of options. The statute thus clearly uses "coverage" to refer to a single "plan." *See Avella v. City of N.Y.*, 29 N.Y.3d 425, 434 (2017) (statute "must be construed as a whole").

The definition of "health insurance coverage" as "*a* program of hospital-surgical-medical benefits" further confirms this reading. § 12-126(a)(iv) (emphasis added; capitalization omitted). Peti-

tioners contend that "program" necessarily means "all of the health insurance plans offered" by the City (Resp. Br. 39), but that reading makes no sense in the context of the statute as a whole. If that phrase were substituted where the local law refers to "health insurance coverage," it would render the text incoherent. Under either party's position, the City's obligation to pay for "health insurance coverage" is not an obligation to pay for "all of the health insurance plans offered," but rather an obligation to pay for a particular plan in which an individual can enroll. The framing of the statutory cap—as equal to "one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis"—confirms this point.

Other uses of the phrase "health insurance coverage" further disprove petitioners' reading. For example, the statute repeatedly refers to "health insurance coverage" predicated on Medicare enrollment, § 12-126(b)(1), (b)(2)(i)–(iv), but that phrase would make no sense if "health insurance coverage" meant the entire panoply of City offerings—most of which are not predicated on Medicare. Similarly, survivors' rights to continue their deceased spouses' "health insurance coverage," so long as they pay for it, would also

be nonsense under petitioners' broad definition. Interpreting "health insurance coverage" to refer to a single plan is the only reading that renders the statute intelligible.

Nor does the definition of "health insurance coverage," in referring to "contracts" and "companies" in the plural, suggest an obligation to pay for multiple plans for each category of insured (Resp. Br. 39–40). As the City explained in its opening brief, a single insurance plan may comprise multiple contracts and companies (City Br. 30–31 n.13). While petitioners complain that they are unaware of any such "multi-company/multi-contract plans" (Resp. Br. 39), Senior Care itself is a combined offering from insurance companies GHI and Empire Blue Cross Blue Shield, just as § 12-126's original benchmark plan was a combination of HIP and Blue Cross (R151, 1321; City Br. 14–15).

Section 12-126's legislative history also confirms that multiple contracts for one plan are not unusual, and that the City Council would have understood that reality when it drafted the local law (R1372–74, 1376–77 (authorizing City to enter into "contracts" with HIP to provide insurance)). Indeed, as Supreme Court

held, § 12-126 does not require the City to offer multiple plans at all, and so the statute's plural usage of "contracts" and "companies" has no bearing on whether the City must pay for each plan offered.

Petitioners further contend that their view is correct because § 12-126 directs that the contracts provide "such health and hospitalization insurance," and in 1965 the now-defunct Board of Estimate's Resolution Calendar No. 292 ("Cal. No. 292") used a similar phrase when addressing healthcare coverage before § 12-126 came into being (Resp. Br. 40).[2] This too is wrong: Cal. No. 292 directed the City to pay for retirees' "*choice* of health and hospital insurance," and to assume "full payment for such health and hospital insurance" (R1344 (emphasis added)). Thus, as used in Cal. No. 292, "such health and hospital insurance" clearly and expressly referred to paying for the retirees' "choice"—language that is nowhere in § 12-126 and cannot inform its proper interpretation. If

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[2] The Board of Estimate historically wielded certain administrative powers and comprised the mayor, comptroller, the City Council president, and the five borough presidents (R1348).

anything, the Board of Estimate's inclusion of express language about "choice" in Cal. No. 292, and the City Council's decision to omit any such language in § 12-126, is just further indication that the latter rejected any obligation to provide each category of insured a "choice" among multiple premium-free plans.

2. Petitioners misconstrue § 12-126's legislative history.

To justify their non-textual view, petitioners also mischaracterize snippets of legislative history divorced from the local law itself. First, petitioners improperly seek to elevate a report from the City Council's Committee on Health and Education—not the City Council as a whole, as petitioners misleadingly claim—as if it were a definitive statement of the legislature's intent (Resp. Br. 6, 28, 36). That report said that the law "would provide that The City of New York pay for the entire cost of any health insurance plan providing for medical and hospitalization coverage of employees and [eligible retirees]" (R1327).

This report cannot bear the weight that petitioners ascribe to it. The "clearest indicator of legislative intent is the statutory

text," *Majewski v. Broadalbin-Perth Cent. Sch. Dist.*, 91 N.Y.2d 577, 583 (1998), and petitioners may not ignore it in favor of the views of a few City Councilpersons. *See Fletcher v. Kidder, Peabody & Co.*, 81 N.Y.2d 623, 634 (1993) (reports "merely set forth the committees' *understanding*" of the law but "say[] nothing about what [legislature] actually *intended*").

Indeed, similar language in the actual law was explicitly rebuffed: determined not to strain the City's resources, Mayor Lindsay vetoed the first bill that would have required the City to pay for "the entire cost of *any* basic health insurance plan" (R1324, 1326 (emphasis added)). That the City Council ultimately scrapped the language petitioners now rely on is "persuasive evidence" that the legislature did so intentionally. *Hazan v. WTC Volunteer Fund*, 120 A.D.3d 82, 86 (3d Dep't 2014); *see N.Y. Civil Liberties Union v. N.Y.C. Police Dep't*, 32 N.Y.3d 556, 567 (2018) (courts may not "second-guess" legislature's determination or "disregard—or rewrite—its statutory text"). While petitioners contend that other amendments addressed Mayor Lindsay's financial concerns (Resp. Br. 45–47), there is no reason to believe that the re-

moval of text obligating the City to pay for "any" plan, as part of the same package of changes, was not likewise intended to be responsive to the Mayor's objection.

In any case, the committee report relied on so heavily by petitioners does not account for *any* of the changes to the bill, including those that petitioners acknowledge were meaningful ones (Resp. Br. 46–47). The second bill made many significant changes: it replaced the obligation to pay for "any basic health insurance plan" with the more bounded term "health insurance coverage"; it defined the scope of that coverage as "a program of hospital-surgical-medical benefits"; it identified eligible employees and retirees, including imposing a five-year service requirement; and it capped the City's payment obligation (R1327). Yet the committee report acknowledged none of these amendments, instead merely repeating verbatim the language previously used to describe the vetoed bill (R1323–34, 1327). These omissions call into serious question whether the committee accurately described § 12-126's amended text, which remains the most reliable guide to the Council's intent.

This Court should also reject petitioners' unfounded assumption that the City Council necessarily shared the Board of Estimate's intent, as reflected in the Board's Cal. No. 292 from 1965 (Resp. Br. 33–35). Far from implementing "nearly identical" language (Resp. Br. 33), the City Council declined to codify the Board of Estimate's earlier decision to pay the full cost of retirees' "choice of health insurance" (R1341–46). That language, of course, is wholly absent from the enacted statute, undercutting, rather than supporting, petitioners' interpretation of § 12-126. Petitioners would have this Court simply "assume the drafters meant something other than what they wrote." *Xiang v. Troon Mgmt., Inc.*, 34 N.Y.3d 167, 172 (2019).

Indeed, principles of statutory construction yet again refute petitioners' interpretation, in this case the idea that the "model" of the Board of Estimate resolution was somehow *implicitly* adopted by the City Council, although it was *explicitly* rejected through the inclusion of more flexible text. The Council easily could have required a choice of premium-free plans in clear terms, but it did not do so. *Kuzmich v. 50 Murray St. Acquisition LLC*, 34 N.Y.3d 84, 93

(2019) (legislature "easily" could have "import[ed]" provisions from other sources); *Trustco Bank v. The Preserve Dev. Grp. Co.*, 190 A.D.3d 1176, 1179 (3d Dep't 2021) (legislature "could have" included additional language and "failure to do so, is presumed to be intentional").

3. Petitioners' interpretation threatens retiree healthcare for no good reason.

Petitioners also ignore the practical import of their claims. They do not dispute Supreme Court's determination that the statute does not require the City to continue offering any specific insurance plan, and in fact requires cancelling all plans that the City does not subsidize (R8–9; Resp. Br. 28, 47–48 (statute requires the City to subsidize only "any offered" plan)). Having withdrawn their cross-appeal, petitioners are bound to that determination. *See, e.g.*, *Brenner v. Brenner*, 52 A.D.3d 322, 323 (1st Dep't 2008) (respondent's failure to cross-appeal barred affirmative relief); *Kent v. Kent*, 29 A.D.3d 123, 130 (1st Dep't 2006) (same); *see generally Hecht v. New York*, 60 N.Y.2d 57, 61–63 (1983) (relief to nonappealing party generally unavailable).

The regime envisioned by petitioners would make little sense. They openly argue that, under their interpretation, the City would have "no incentive" to adjust its healthcare offerings as the market evolved—even over decades—because "its payment obligation would remain the same regardless" (Resp. Br. 48). But petitioners never confront how odd it would be for the City Council to require the City to pay the same amount for any healthcare offering, leaving no space for market competition or other developments to achieve taxpayer savings.

Indeed, the City is duty-bound to "assure the prudent and economical use of public moneys" and to negotiate contracts "of maximum quality at the lowest possible cost." Gen. Mun. Law § 100-a. Yet creating a statutory obligation that would force the City to pay for all healthcare plans up to the price of the applicable HIP plan would undermine that policy by hamstringing the insurance market: a competitor who might otherwise offer premiums lower than HIP would have little incentive to do so knowing that the City's payment mandate was tied to HIP's rates.

Nor is petitioners' assertion correct in any event. Though it is hard to understand precisely how petitioners construe § 12-126's text, their reading seemingly would not eliminate the potential incentive to alter plan offerings. Instead, it would only mean, rather illogically, that the City would need to find *two* plans that were available at lower costs before realizing fiscal savings. Contrary to petitioners' assertion, in times of financial stress,[3] their reading would leave the City little alternative but to remove retiree options—rather than simply allow competition on price—thus limiting the very "choice" that petitioners claim to protect (Resp. Br. 48–49). The City Council could not have intended such a self-defeating design.

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[3] Petitioners dismiss the City's fiscal concerns (Resp. Br. 8–9 n.5), but the fact is that the City faces remarkable financial headwinds, including a $10 billion budgetary shortfall expected in just a few years. Office of the N.Y.S. Comptroller, *Review of the Financial Plan of the City of New York* (2022), *available at* https://perma.cc/ME6J-8FKC. Addressing these concerns, and specifically citing rising healthcare costs, the City recently directed its agencies to find hundreds of millions of dollars in additional savings by cutting spending—the second such reduction in just two years. Jeff Coltin, *With a New Austerity Measure, Mayor Eric Adams Asks Agencies to Cut Budgets by 3%*, City & State (Sept. 12, 2022), https://perma.cc/CNC9-MZPH.

Highlighting petitioners' disregard for the realities of their position, they even contend that the use of *any* Medicare Advantage plan would per se violate § 12-126 because the federal government, rather than the City, would pay for it (Resp. Br. 49).[4] Nothing in § 12-126 supports the extraordinary view that the City Council would have intended to prevent the City from relieving burdens on city taxpayers where federal subsidies were sufficient to cover the full cost of quality healthcare coverage. *See People of the State of N.Y. ex rel. McCurdy v. Warden, Westchester Cnty. Corr. Facility*, 36 N.Y.3d 251, 262–63 (2020) (rejecting construction of a statute that would lead to "absurd results").

Such a result is not just illogical but wholly unsupported. The City Council enacted the original version of § 12-126 in 1967, after Medicare had been enacted and the City began to offer only supplemental Medigap plans for Medicare-eligible retirees (R1320, 1339; City Br. 7–11). The City has thus long looked to the federal

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[4] Petitioners' current plan, Senior Care, is itself a Medigap plan that supplements, rather than duplicates, the substantial benefits funded by the federal government under Medicare (City Br. 15).

government to pay for at least some of the health insurance coverage that retirees receive, as § 12-126 itself recognizes. *See* § 12-126(b)(1) (permitting health insurance coverage to be "predicated" on enrollment in Medicare). There is no reason to conclude that the City Council meant to allow the federal government to cover some of the costs of coverage, including for Senior Care enrollees, yet foreclose federal subsidies that would reduce the "entire cost," for both retirees and the City, even further. The City Council could not have intended to burden City taxpayers—who are generally net donors to the federal government—by requiring the City to reject federal monies.

4. Petitioners' misleading accusation that the City has inconsistently interpreted § 12-126 is meritless.

Petitioners' final gambit—that the City previously took a contrary view of § 12-126—is false and, in any event, irrelevant. The City has historically offered more than one premium-free plan only pursuant to collective bargaining, not because § 12-126 required it. Indeed, contrary to petitioners' claims (Resp. Br. 42), past practice has *not* mirrored their interpretation of § 12-126,

and the City has often paid *more* for Senior Care than the cap set by HIP VIP HMO—by agreement with municipal unions (City Br. 14–15). Those subsidies are in no way a statement on § 12-126's reach.

Misrepresenting the City's complaint in *City of New York v. Group Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006), petitioners contend that the City agreed with them in that case (Resp. Br. 30–31, 41). But that pleading actually alleged that "the City, *through its collective bargaining agreements* and by local law, N.Y.C. Admin. Code § 12-126, [was] required to contribute for health insurance" for more than one plan. Compl. ¶¶ 30–31, *Grp. Health Inc.*, No. 06-CV-13122 (emphasis added).[5] This, of course, describes the City's exact position here: that § 12-126 identifies a statutory floor, not a ceiling, and that the City had previously

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[5] Petitioners similarly mischaracterize the Second Circuit's related decision (Resp. Br. 42–43), which confirmed the City's position that "[u]nder municipal law and *by agreement between the City and the Municipal Labor Committee*, the City pays the entire premium for employees who enroll in either the HIP plan or the GHI plan." *City of N.Y. v. Grp. Health Inc.*, 649 F.3d 151, 154 (2d Cir. 2011) (emphasis added).

agreed through collective bargaining to subsidize multiple plans (City Br. 14).

Similarly misleading is petitioners' claim that the City Law Department previously endorsed their view (Resp. Br. 31). In a backdoor effort to supplement the appellate record, petitioners filed a misguided, mid-appeal sanctions motion in Supreme Court that misrepresented a few words from a City attorney's 2016 legal advice—primarily concerning the local law's application to copayments, a completely different aspect of § 12-126 (*see* NYSCEF No. 229 (City's opposition)). Supreme Court promptly denied the motion (NYSCEF No. 231), and for good reason: it is fundamentally misguided to characterize a single, nonbinding letter, which emphasized the City's ability to adapt to industry conditions under § 12-126, as proof that the local law requires the City to subsidize multiple plans.

What's more, petitioners ironically claim that the City's interpretation of § 12-126 over time is "controlling" (Resp. Br. 41–43 (citing *Kolb v. Holling*, 285 N.Y. 104, 113 (1941) (according "great

weight" to state government's interpretation of state law))),[6] yet also merits no deference now that the City has explained that petitioners' description of the City's position is wrong (Resp. Br. 44–45). Petitioners cannot have it both ways.

On these bases alone, this Court should vacate Supreme Court's injunction. Section 12-126 is wholly satisfied through the City's provision of a single, premium-free healthcare plan that retirees are free to decline. Petitioners' contrary interpretation, to the extent they offer one, ignores the statute's text, mischaracterizes its legislative history, and contravenes the City Council's purpose.

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[6] Petitioners' description of *Kolb* is wrong. In that case, the Court deferred to the New York State legislature and several State government officials' view that a new State constitutional provision did not require ending the City of Buffalo's past practices under State law. *Kolb*, 285 N.Y. at 112–13. *Kolb* did not hold, as petitioners claim, that the City of Buffalo's past actions themselves determined the constitutional amendment's intent (Resp. Br. 43). Nor does *Polan v. State of New York Insurance Dep't*, 3 N.Y.3d 54, 63 (2004), support petitioners, which rejected an interpretation that would have upended the entire insurance industry. The City's interpretation of § 12-126 recognizes petitioners are entitled to a premium-free healthcare plan, as they always have been.

B. Petitioners' claims regarding § 12-126's statutory cap are likewise meritless.

For the reasons above, § 12-126 requires the City to provide only one premium-free insurance option. But even if that were not so, any obligation to subsidize additional plans is capped at the "full cost of H.I.P.-H.M.O. on a category basis." Since HIP's HMO products became the statutory cap in 1984, the only HMO from HIP offered to Medicare-eligible retirees has been a plan that supplements Medicare's federal benefits and is therefore much less expensive than an active-employee plan. Petitioners raise a host of meritless procedural claims to force the City to pay up to the higher active-employee rate, yet offer not one valid reason that the City Council would have enacted a bill that ignores the basic reality that Medicare-eligible retirees receive most of their insurance coverage from the federal government.

1. The cap issue was raised below, and is in any event a pure question of law available for this Court to resolve.

Petitioners first assert that the City "affirmatively conceded" that the applicable statutory cap for all retirees, regardless of

Medicare-eligibility, is HIP's higher rate for active employees (Resp. Br. 51). But the City at no point accepted petitioners' position on the cap, notwithstanding their mischaracterization of the City's papers (Resp. Br. 51 & n.34; *see* NYSCEF No. 201 at 2, 5 (City's brief describing petitioners' views and arguing in the alternative)).

To be clear, the City argued below that the statutory cap for Medicare-eligible retirees was the HIP HMO plan actually available to them as a separate category of insured (R1970–71 (NYSCEF No. 212)); an amicus curiae presented the same argument as well (NYSCEF No. 205 at 15–16); petitioners had an opportunity to—and did—respond to that argument below (NYSCEF Nos. 208, 213); and Supreme Court specifically confirmed that all of these submissions were considered in resolving the petition (R7). There is no barrier to this Court's consideration of the point on appeal. *See, e.g.*, *U.S. Bank N.A. v. DLJ Mortg. Capital, Inc.*, 33 N.Y.3d 84, 89 (2019) (argument preserved if party asked Supreme Court to resolve it); *Geraci v. Probst*, 15 N.Y.3d 336, 342 (2010) (one party's argument sufficiently "alert[ed] Supreme Court to the rele-

vant question," even if another's did not); *Kennelly v. Mobius Realty Holdings LLC*, 33 A.D.3d 380, 382 (1st Dep't 2006) (appellate court may consider new claim or evidence where adversary responded below).

Even setting these points aside, "question[s] of statutory interpretation" may be raised "for the first time on appeal." *Aldrich v. N. Leasing Sys., Inc.*, 168 A.D.3d 452, 453 (1st Dep't 2019), given that "their resolution does not hinge on the record evidence." *Chambers v. Old Stone Hill Rd. Assocs.*, 303 A.D.2d 536, 538 (2d Dep't 2003). Whether the cap "on a category basis" refers to the HIP HMO plan for Medicare-eligible retirees can be discerned from the statute's plain text.

Nor does petitioners' characterization of this issue as "fact-intensive" bar this Court's review (Resp. Br. 50). Although petitioners dispute the cost of HIP VIP HMO (Resp. Br. 54), this Court need not determine the cap's specific amount to resolve the interpretive issue here. Instead, the only question for this Court is statutory: whether § 12-126's language capping expenditures for Medicare-eligible retirees at "the full cost of H.I.P.-H.M.O. on a

category basis" refers to the Medicare-dependent HIP HMO available to those retirees, or the more expensive active-employee plan.

2. Petitioners' interpretation of the statutory cap ignores the text of § 12-126, as well as Medicare's wide-ranging impact on retiree healthcare.

Turning to the merits, this Court should reject petitioners' claim that the relevant HIP HMO plan for Medicare-eligible retirees is a plan for individuals who are not eligible for Medicare. Because of Medicare's availability, the cost to the City of insuring Medicare-eligible retirees is *dramatically* lower than the cost for those ineligible for Medicare. A cap that fails to recognize that basic reality renders the cap a nullity for the category of Medicare-eligible individuals. For instance, petitioners openly argue that the current $776 cap for Medicare-ineligible enrollees also applies to Medicare-eligible ones (Resp. Br. 50), even though the $776 amount is four times greater than the premiums for their current Medigap plan. Only the clearest expression of legislative intention should suffice to support such a radical outcome.

Petitioners can muster nothing close. In fact, the text of § 12-126 only confirms the City's understanding that the relevant plan here is the HIP HMO available for Medicare-eligible individuals—known as HIP VIP HMO. That understanding was expressly built into the law through (a) the cap's reference to "the full cost of H.I.P.-H.M.O. on a category basis," and (b) the law's consistent and explicit recognition that health care coverage "predicated on the insured's enrollment in" Medicare is its own distinct category of coverage. § 12-126(b)(1), (b)(2)(i)–(iv).

Petitioners contend that "category basis" refers to only individual versus family coverage (Resp. Br. 56–58) yet ignore that the only distinct "categor[ies]" of coverage that the statute expressly identifies are (a) those eligible for Medicare and (b) those who are not. Section 12-126 itself recognizes that coverage between those two categories is *different*: those ineligible for Medicare get full coverage, while those who are eligible receive "health insurance coverage … predicated on the insured's enrollment in [Medicare]." In at least five different places, the local law distinguishes in close succession between (a) "health insurance cover-

age" *simpliciter* and (b) "health insurance coverage which is predicated on the insured's enrollment in [Medicare]." § 12-126(b)(1), (b)(2)(i)–(iv). The text thus confirms the City Council's understanding that Medicare-eligible individuals constitute their own category, distinct from others. *Id.*

Petitioners argue that "there is and always has been one single insurance plan that sets the statutory cap," which they claim is the plan for active employees (Resp. Br. 55). But that is not true. Petitioners' contention ignores that the offering identified in § 12-126, including upon its original enactment, has always distinguished between those eligible for Medicare and those who were not. Since 1966, those ineligible for federal benefits were entitled to complete coverage through the City, while Medicare-eligible retirees received less expensive coverage that was only supplemental to Medicare (R1338–39 (City offered only supplemental coverage to Medicare-eligible retirees upon § 12-126's enactment); R1414–17 (HIP HMO offers "primary" coverage to those

under 65 but did not "duplicate" federal benefits for Medicare-eligible retirees)).[7]

Nor did either of the Board of Estimate resolutions that petitioners cite impose any limits on what constitutes a "category," much less constrain it to only individual and family coverage (Resp. Br. 56–58). As explained above, the City Council rejected most of the operative language that the Board of Estimate adopted, and the Board's intent cannot be ascribed directly to the Council. In any event, petitioners pretend that Medicare had no impact on the Board's resolutions, but Cal. No. 292—adopted after Medicare had already been enacted—expressly commissioned a study regarding Medicare's effect on the City's insurance offerings (R1347).

Both the Board and the City Council were thus well aware that Medicare would create a new category of insured, which the

[7] Petitioners again claim that the City conceded their argument (Resp. Br. 55), but the City's brief cited for that proposition never identified the "particular plan" that applied to petitioners (NYSCEF No. 201 at 2–3). Nor does *New York 10-13 Ass'n v. City of New York*, No. 98 Civ. 1425 (JGK), 1999 U.S. Dist. LEXIS 3733, at *36 (S.D.N.Y. Mar. 30, 1999), support petitioners, which also did not identify the applicable HIP HMO plan.

City immediately incorporated into its healthcare offerings before § 12-126's passage (R1339, 1347). Against this swiftly changing landscape in the healthcare industry, this Court should not create a limitation upon the term "category" that neither the City Council nor the Board of Estimate ever suggested, much less wrote into the law.[8]

Moreover, even if Medicare-eligible retirees were not a statutory "category," that would not alter the outcome. To imply from the legislative text that a cost standard applicable to these retirees is derived from a plan that cannot include them—and thus has premiums that are actuarially irrelevant to them—would be to embrace an absurd result. The only reasonable understanding is that HIP VIP HMO—a plan that is actually designed for Medicare retirees—constitutes the relevant HIP HMO for this purpose.

The practical effect of petitioners' shortsighted reading confirms its flaws. At present, the City offers many plans to Medi-

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[8] Petitioners also point to a 2008 collective bargaining agreement's reference to "category basis" (Resp. Br. 56 (citing R606)), but that definition is plainly irrelevant to the City Council's intent when enacting § 12-126 in 1967.

care-eligible retirees other than petitioners' current plan, including some "deluxe" plans that require enrollees to pay hundreds of dollars per month. *See, e.g.*, N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of Jan. 1, 2022* (2021), *available at* https://perma.cc/HFM8-8463. If § 12-126 forced the City to ignore the role that Medicare plays and pay up to the $776 active-employee rate for every retiree, even those who seek the most expensive insurance, the City's taxpayers would realize little to none of the benefits of Medicare's subsidies. Instead, those savings would go to individual retirees, who would reap the windfall in the form of free "deluxe" insurance on top of the benefits that the federal government already provides. The City Council, which specifically provided that some retirees would receive insurance only "predicated on" Medicare, could not have intended that result.

Petitioners' remaining efforts to rewrite § 12-126 also fail. That the City has historically paid for Senior Care is irrelevant (Resp. Br. 58), given that the City did so pursuant to its collective bargaining agreements, not § 12-126 (City Br. 14–15). The more telling fact is that the City long has not paid the full premium for

the "deluxe" Medigap plans, as petitioners' position would seemingly require. And as explained above, the Court should also reject petitioners' reliance on 2016 legal advice from a City attorney, primarily on a different aspect of § 12-126, that in any event is outside the appellate record and does not bind the City (Resp. Br. 58–59; *see* NYSCEF No. 229 at 1–2 (City's opposition to sanctions motion); NYSCEF No. 231 (order denying motion)). And, because this Court's task on the cap issue is only to interpret whether § 12-126's reference to "the full cost of H.I.P.-H.M.O. on a category basis" includes Medicare eligibility, the Court need not concern itself with petitioners' disagreement with the applicable cap's amount (Resp. Br. 59–61).

* * *

For all of these reasons, the City's interpretation of § 12-126 is by far the better one. The City Council did not intend to tie the City's hands and force it to reject federal subsidies in providing retirees premium-free healthcare, or to pay exorbitant rates that ignore Medicare's role in retiree coverage. Nor did the Council seek to inhibit retiree choice by preventing them from electing more

expensive plans that they choose to pay for. Section 12-126's text, confirmed by its legislative history, instead allows the City the necessary flexibility to make fiscally responsible choices while continuing to ensure that retirees receive the free, high-quality healthcare coverage that they need.

CONCLUSION

This Court should vacate the order below and deny the petition in its entirety.

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September 16, 2022

Respectfully submitted,

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