Index No. 154962/2023

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,

- against -

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.

RESPONDENTS-DEFENDANTS' MEMORANDUM OF LAW IN OPPOSITION TO THE VERIFIED PETITION AND TO PETITIONERS' MOTION FOR PRELIMINARY INJUNCTION

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Index No. 154962/2023

Hon. Lyle E. Frank

Motion Seq. No. 002

RESPONDENTS-DEFENDANTS' MEMORANDUM OF LAW IN OPPOSITION TO THE VERIFIED PETITION AND TO PETITIONERS' MOTION FOR PRELIMINARY INJUNCTION

Respondents-Defendants (collectively, the "City" or "Respondents") respectfully submit this Memorandum of Law in Opposition to the Verified Petition and Motion for Preliminary Injunction. Respondents incorporate, by reference, the previously filed papers under this index number, 154962/2023.

PRELIMINARY STATEMENT

Petitioners commenced this Article 78 proceeding to challenge the City's decision to implement the Aetna Medicare Advantage plan ("Aetna MAP"), a customized, comprehensive, premium-free health plan designed for New York City's approximately 250,000 Medicare-eligible retired municipal employees ("Retirees"). Aetna MAP will enable the City to achieve savings of over $500 million by taking advantage of federal Medicare Advantage subsidies, and thereby ensure that the City can continue to offer quality health coverage over the long term even amid rising healthcare costs.

Though Petitioners purport to speak on behalf of all retired municipal employees and their dependents, they consist of just one nonprofit organization and eight individual Retirees. The Petition asserts several causes of action, but at its crux are the false ideas that the City has no right to change Retirees' health benefits, and that Aetna MAP degrades those benefits.

Petitioners' claim for promissory estoppel, Count 1, is meritless because the City did not promise Petitioners that their health care would never change. Count 2, premised on allegations that the City is reducing Retiree health benefits out of line with active municipal employee benefits, fails because Aetna MAP will not diminish Retiree benefits, and indeed will continue to offer retirees with greater coverage than active employees enjoy. Petitioners' claim that that Aetna Map will cause a "dangerous disruption" to Retirees' care, Count 3, relies on baseless speculation, and is belied by the fact that at least 97% of providers who have accepted the current most popular Retiree health plan, Senior Care, have indicated that they will also accept Aetna MAP or payment from Aetna. *See infra*, n.10. The City will pay 100% of Aetna MAP premiums for Retirees and their dependents, which satisfies the City's obligations to Retirees under Administrative Code § 12-126, and defeats Petitioners' claim under that statute, Count 5.

Petitioners' Counts 4 and 10 rely on allegations that the City has in some way failed to fully or accurately inform Retirees about Aetna MAP, but these claims must fail because the City and Aetna have in fact provided Retirees with comprehensive information about the new plan through both written materials sent by mail, as well as the New York City Office of Labor Relations ("OLR") and Aetna websites and informational meetings across the country. The disability discrimination claims, Counts 6 and 7, are not properly pleaded because the Petition lacks allegations suggesting that the City's implementation of Aetna MAP has had an adverse disparate impact on disabled Retirees, or that disabled Retirees were discriminated against because of their membership in a protected class. Petitioners' Count 11, the Donnelly Act antitrust claim is fundamentally misguided, because neither the Petitioners, the City, nor Aetna Life Insurance Company ("Aetna") are in competition with each other. Count 9, alleging violation of the New York City Administrative Procedure Act ("CAPA"), must be denied because it does not apply to internal City personnel matters. Count 12 for violation of Article V, Section 7 of the New York Constitution is similarly meritless because Article V, Section 7 does not apply to health insurance benefits. Petitioners' unjust enrichment claim, Count 8, is duplicative of the other claims, and must also fail because Aetna MAP does not unjustly enrich the City. All savings from the implementation of the new plan will be directed to a fund controlled by the City and the Municipal Labor Committee, which will jointly administer the fund for the benefit of not just the City, but also municipal employees and Retirees.

Because Petitioners' claims are uniformly meritless and the City is not violating any of Petitioners' rights by the implementation of the Aetna MAP, the Petition must be denied.

SUMMARY OF RELEVANT FACTS

For a full statement of the relevant facts, the Court is respectfully referred to the Respondents' Verified Answer ("Ans."), particularly the statement of pertinent and material facts. *See* Ans. ¶¶ 397-506.

ARGUMENT

POINT I

PETITIONERS' PROMISSORY ESTOPPEL CLAIM IS MERITLESS

A. Petitioners Fail to Identify a Clear and Unambiguous Promise By Respondents

To succeed on their promissory estoppel claim, Petitioners must establish "a clear and unambiguous promise, reasonable and foreseeable reliance by the party to whom the promise is made, and an injury sustained in reliance on that promise." *Odonata Ltd. v. Baja 137 LLC*, 206 A.D.3d 567, 569 (1st Dep't 2022). Promissory estoppel, in contrast to equitable estoppel, requires "a statement of intention regarding future conduct," as opposed to a representation regarding "existing fact." *Field v. Citimortgage, Inc.*, No. 151912/2012, 2013 N.Y. Misc. LEXIS 4680, at *9 (Sup. Ct. N.Y. Cnty. Oct. 11, 2013) (Singh, J.) (citing 57 N.Y. Jur.2d, Estoppel, Ratification and Waiver, § 51). A promissory estoppel claim based on an indefinite or ambiguous promise must fail. *See, e.g.*, *Randall's Is. Aquatic Leisure, LLC v. City of New York*, 92 A.D.3d 463, 464 (1st Dep't 2012) (affirming dismissal of promissory estoppel claim because alleged "statement that 'possible loans' were being 'considered'" was "not an allegation of clear and unambiguous promises"); *Richbell Info. Servs. v. Jupiter Partners, L.P.*, 309 A.D.2d 288, 304 (1st Dep't 2003) (alleged promise to carry out an IPO within nine months "was too indefinite to be the type of clear and unambiguous promise required for promissory estoppel").

Petitioners' promissory estoppel claim relies on statements in the SPDs to the effect that currently, the City's Health Benefits Program provides retirees over the age of 65 with insurance which supplements benefits provided by Medicare. Pet. ¶¶ 248-54. SPDs are issued annually and contain information about what insurance plans are being offered that year. *Id.* ¶ 245. Petitioners allege that the SPDs are "[t]he authoritative source of information about the Health Benefits Program," but the SPDs contain qualifying language that belies this assertion. *Id.* For instance, the 1994 SPD states that "[t]his Summary Program Description is for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws." Affidavit of Marianne Pizzitola in Support of Petition ("Pizzitola Aff."), NYSCEF Doc. No. 10 at 9. The introduction to the 1983 SPD warns that "rising healthcare costs," along with other factors, "could limit the possibility of future benefits," making clear that the SPDs are simply an attempt to describe City Health Benefits Program members' current benefits, not a guarantee about the future. Pizzitola Aff., NYSCEF Doc. No. 8 at 3.

The most recent SPD cited by Petitioners specifically states, in the present tense, that "[t]he City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare." Pet. ¶ 254 (citing Pizzitola Aff., NYSCEF Doc. No. 22 at 19). Petitioners further cite numerous prior SPDs which contain substantially identical statements regarding the supplemental insurance that the City also provided under that years' Health Benefits Program. *Id.* ¶¶ 248-53. Additionally, Petitioners allege that throughout the decades, City agencies, labor unions, human resources officers, and others repeated the SPDs' guidance regarding insurance which supplements benefits provided by Medicare. *Id.* ¶¶ 255-60.[1] Because the City

[1] As with the SPDs, the other guidance that Petitioners' received regarding their health benefits came with caveats that made clear that the guidance was not binding. For instance, Petitioners cite a Summary of Benefits published by the City University of New York which states:

consistently offered Medicare supplemental plans "for over 50 years," Petitioners allege that it was "unthinkable" that the City would ever cease offering that coverage in favor of a Medicare Advantage plan. *Id.* ¶¶ 255, 260.

But the fact that Petitioners allegedly came to rely on the City's pattern of continually offering insurance which supplements benefits provided by Medicare throughout the decades does not convert what was a statement of then-existing fact regarding the City's Health Benefits Program into a "clear and unambiguous" forward-looking promise sufficient to support a promissory estoppel claim. *See Randall's Is. Aquatic Leisure, LLC v. City of New York*, No. 111146/2009, 2010 N.Y. Misc. LEXIS 3952, at *5, *16-19 (Sup. Ct. N.Y. Cnty. July 20, 2020) (Smith, J.), *aff'd* 92 A.D.3d 463 (1st Dep't 2012) (dismissing promissory estoppel claim based on allegations that municipal defendants had previously repeatedly extended plaintiffs' deadlines to secure financing to build a park, along with other allegations supporting the conclusion that "given all of the circumstances, [plaintiffs'] assumption that an [additional] extension would be granted was reasonable," because this did not constitute a "'clear or unambiguous' promise to grant an additional extension").[2]

> The University Benefits Office provides the Summary of Benefits solely for information purposes and although every effort has been made to assure its accuracy, it is the interpretations and rules of the benefit providers and retirement systems that are binding. This handbook does not create a contract, nor does it assure that particular benefits will be provided. If any discrepancies exist between the information presented herein and the information contained the plan documents, the actual provisions of each benefits plan will govern. These benefits are subject to change at any time, with or without notice.

Pizzitola Aff., NYSCEF Doc. No. 24 at 3.

[2] In addition to the SPDs' statements regarding insurance which supplements benefits provided by Medicare, Petitioners also quote language from past SPDs stating that "[w]hen you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) . . . your first level of health

"It is never to be assumed . . . that the State has fettered its power in the future" absent "clear and irresistible evidence" to the contrary. *Pennsylvania R. Co. v. State*, 11 N.Y.2d 504, 511 (1962). Applying this principle, appellate courts have repeatedly held that, where a government employer declares its rules or policies regarding retiree health benefits, those rules or policies are non-binding and may be altered by the government entity at its option. *E.g.*, *Taranto v. City of Glen Cove*, 212 A.D.3d 826, 827-28 (2d Dep't 2023) (denying Article 78 petition to estop City of Glen Cove from terminating retired city attorney's health insurance benefits); *Weaver v. Town of N. Castle*, 153 A.D.3d 531, 533-34 (2d Dep't 2017) (Town of North Castle "was not barred by the doctrine of promissory estoppel from reducing the appellants' retirement health insurance benefits" that had been afforded pursuant to prior municipal resolution), *Iasillo v. Pilla*, 120 A.D.3d 1192, 1192-1194 (2d Dep't 2014) (affirming summary judgment dismissal of claim to estop Village of Port Chester from terminating retired elected official's health care benefits that had been afforded pursuant to multiple prior resolutions); *Handy v. County of Schoharie*, 244 A.D.2d 842, 843-844 (3d Dep't 1997) (denying Article 78 petition to estop County of Schoharie from altering health insurance benefits provided to retired elected officials). Similarly, in *Donahue v. Cuomo*, which involved a challenge to New York State's determination to reduce contributions

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benefits is provided by Medicare." Pet. ¶ 253 (quoting Pizzitola Aff., Ex. 12 at 14). This sentence, like the statements regarding insurance which supplements benefits provided by Medicare, is written in present tense and refers only to the then-current state of the City's Health Benefits Program, despite the fact that it makes a forward-looking statement regarding the first level Medicare coverage Retirees might obtain upon turning 65. In any event, the Retirees' first level Medicare coverage is not what is at issue in this case. Retirees who change their coverage from Senior Care to Medicare Advantage continue to receive Medicare Part A and Part B coverage. *See Things to Know About Medicare Advantage Plans*, MEDICARE.GOV, https://www.medicare.gov/sign-upchange-plans/types-of-medicare-health-plans/things-to-know-about-medicare-advantage-plans (noting that Medicare Advantage enrollees "still get complete Part A and Part B coverage through the plan. Plans may offer some extra benefits that Original Medicare doesn't cover – like vision, hearing, and dental services.").

to its retirees' health insurance premiums, the Court of Appeals declined to rule against the state because the governing collective bargaining agreement did not "*expressly* provide for a vested right to coverage at fixed contribution rates." *Donohue v. Cuomo*, 38 N.Y.3d 1, 17-19 (2022) (emphasis in original); *see also Donahue v. Hochul*, 32 F.4th 200, 203 (2d Cir. 2022) ("[w]ith the benefit of the New York Court of Appeals's guidance" in *Donahue v. Cuomo*, affirmed summary judgment dismissal of challenge to state's reduction of contributions to its retirees' health insurance premiums).

The Second and Third Departments' *Taranto* and *Handy* decisions are particularly instructive. While the petitioner in *Taranto* was still employed by the City of Glen Cove as the city attorney, the director of personnel for Glen Cove allegedly told him that he would continue to receive health insurance benefits after his retirement. 212 A.D.3d at 827. However, five years after the petitioner retired, Glen Cove passed a resolution which terminated the petitioner's retirement health benefits. *Id.* Although the petitioner sought estoppel of that resolution, the Second Department denied the petition, holding that despite whatever assurances the petitioner was given about Glen Cove's health insurance benefits before he retired, "[l]ocal governments are free to terminate retirement health insurance and other benefits they may have previously elected to provide to employees and other officials." *Id.* at 828.

The *Handy* petitioner similarly sought to prevent a public entity, the County of Schoharie Board of Supervisors, from changing its rules regarding retiree health insurance. 244 A.D.2d at 843. The Board of Supervisors passed a series of motions setting a policy with respect to the provision of health insurance benefits shortly before the petitioner retired, but then rescinded those motions shortly after the petitioner retired. *Id.* The Third Department held that "absent clear evidence that [the Board] intended to fetter its power in the future," the Board's motions must be

read only as a declaration of current policy regarding health insurance "to be pursued until the [Board] shall ordain otherwise." *Id.* (internal quotation marks and brackets omitted). Respondents in this proceeding, like the respondents in *Taranto* and *Handy*, have in the SPDs made declarations of fact regarding the City's current Health Benefits Program, not forward-looking promises. Petitioners have provided no evidence, let alone "clear and irresistible evidence" that Respondents intended to be bound by those rules in the future. Thus, Petitioners have failed to identify a "clear and unambiguous promise" sufficient to support their promissory estoppel claim.

Petitioners' Brief quotes the Second Circuit's *NRP Holdings LLC v. City of Buffalo* decision, which affirmed dismissal of a promissory estoppel claim against municipal entities, but also recognized that in some other cases, New York courts "have permitted estoppel claims against municipal entities to proceed where individual persons relied to their detriment on a [public entity]'s erroneous promises concerning . . . their financial benefits as public employees." Br. at 23 (quoting 916 F.3d 177, 203 (2d Cir. 2019)). The Brief also cites examples of such decisions, namely *Agress v. Clarkstown Central School District, Allen v. Board of Education, Vassenelli v. City of Syracuse, Branca v. Board of Education*, and *Abbruscato v. Empire Blue Cross and Blue Shield*. *Id.* at 23, 31, 35-36. However, each of these cases is distinguishable and thus inapposite here.

The *Agress* court allowed a retired school psychologist's claim to estop the school district from ending her health benefits to survive summary judgment because (1) even though the retiree had no right to health insurance benefits under the school district's retirement benefits rules, the school district's employees erroneously represented that she did have such a right, and (2) the school district allegedly ratified those representations by allowing her to maintain her health insurance benefits for years after her resignation, in contravention to its own purported rules. 69

A.D.3d 769, 770-772 (2d Dep't 2010). Thus, unlike here, where Petitioners have failed to identify any incorrect statements or false promises by Respondents, the *Agress* plaintiff alleged an error that was attributable to the defendants.

So too, the *Allen* case is inapposite: there, the defendants' representatives allegedly made a forward-looking promise that the plaintiffs "had a secure right to have the defendants make lifetime health insurance premium contributions." 168 A.D.2d 403, 404 (2d Dep't 1990). The *Allen* court denied summary judgment because there was an issue of fact regarding whether the defendants "explicitly . . . authorized" those representations. *Id.* The City has made no forward-looking promise here, nor is there evidence that a forward-looking promise was authorized by the City.

Vassenelli held that the plaintiff disabled police officer had stated a promissory estoppel claim against the defendants for terminating his health benefits, though the decision contains no discussion of the alleged promise at issue. 138 A.D.3d 1471, 1475 (4th Dep't 2016). The operative underlying complaint, however, alleged that the defendants promised the plaintiff that "when he became disabled . . . the City would pay for all of his medical treatment, services, and hospital care necessitated by reason of such injury or illness." Index No. 2014EF97, NYSCEF Doc. No. 112 at ¶ 23. Thus, unlike here, the *Vasinelli* decision involved a forward-looking promise sufficient to support a promissory estoppel claim.

Finally, *Branca* and *Abbruscato*, unlike this proceeding, both involved clear and unambiguous written statements by government employers regarding contemplated future benefits to employees that were later withheld. *Branca*, 239 A.D.2d 494, 495 (2d Dep't 1997); *Abbruscato*, 274 F.3d 90, 97, 100-02 (2d Cir. 2001). In *Branca*, the employer passed a resolution stating that certain employees would receive increases in compensation and fringe benefits, and then later

refused to pay the increases. 239 A.D.2d at 495. And in *Abbruscato*, the employer provided employees with documents informing them of "lifetime" benefits that the employer later reduced. 274 F.3d at 97, 100-02.

In addition to failing to identify a clear and unambiguous promise by Respondents, Petitioners' also fail to allege the other elements of promissory estoppel, namely reasonable and foreseeable reliance by the party to whom the promise is made and an injury sustained in reliance on that promise. *See Odonata Ltd.*, 206 A.D.3d at 569. Since Respondents' statements about current Retiree benefits were not promises, any reliance by Petitioners on those statements was not reasonable. *See North American Realty Advisory Services, L.P. v. Flint*, No. 89 Civ. 5351 (LMM), 1992 U.S. Dist. LEXIS 4772, at *8 (S.D.N.Y. Apr. 10, 1992) (plaintiff's alleged reliance on statement that was not a clear and unambiguous promise was not reasonable). And Petitioners will not suffer injury because, contrary to their allegations, and as is set forth more fully in Respondents' Verified Answer (Ans.), Aetna MAP is a high-quality insurance plan that will provide Retirees with comprehensive health care.

Because Petitioners fail to identify a clear and unambiguous promise by Respondents, or the other required elements, Petitioners' promissory estoppel claim should be denied.

B. Estoppel Claims Against Government Entities, Including Respondents, are Barred Under New York Law

It is long-established that, under New York law, "estoppel is not available against a governmental agency engaging in the exercise of its government," with limited exceptions. *Advanced Refractory Techs., Inc. v. Power Auth.*, 81 N.Y.2d 670, 677 (1993) (dismissing promissory estoppel claim against Power Authority of the State of New York); *New York State Medical Transporters Ass'n v. Perales*, 77 N.Y.2d 126, 130 (1990) (holding that "estoppel against

a governmental agency . . . is foreclosed in all but the rarest of cases," and dismissing estoppel claim against commissioner of state agency) (internal quotation marks omitted). These rare exceptions "usually involv[e] the wrongful or negligent conduct of a governmental subdivision, or its misleading nonfeasance, which induces a party relying thereon to change his or her position to his or her detriment resulting in manifest injustice." *Taranto*, 212 A.D.3d at 827 (internal quotation marks omitted).

Petitioners' Brief asserts that "no showing of manifest injustice . . . is technically required" except in cases involving the government carrying out a "statutory duty" or "rectifying an administrative error," but they cite no authority to support this proposition. Br. at 23. In fact, the bar on estoppel claims against state or municipal entities applies as long as the agencies at issue were "acting in a governmental capacity" with respect to the conduct at issue. *Brown v. New York State Teachers' Retirement System*, 107 A.D.2d 103, 109 (3d Dep't 1985) (affirming summary judgment motion dismissing estoppel claim regarding disputed pension benefits received from New York City Police Pension Fund). "This rule has been applied consistently in the area of public retirement." *Id.* (citing cases); *e.g. Taranto*, 212 A.D.3d at 828 (applying rule barring estoppel claims against government entities in decision dismissing Article 78 challenge to public entity's administration of retirement benefits); *Westmorland v. New York State & Local Retirement Sys.*, 129 A.D.3d 1402, 1404-1405 (3d Dep't 2015) (same); *Leisten v. McCall*, 285 A.D.2d 897, 899 (3d Dep't 2001) (same). *See also Barbera v. New York City Employees Retirement Sys.*, 211 A.D.2d 406, 408 (1st Dep't 1995) ("[E]stoppel generally will not bar the government from changing its position in the exercise of a governmental function such as its management of [a] retirement plan.").

As discussed *supra*, Petitioners entirely fail to allege any forward-looking promise by Respondents sufficient to support a promissory estoppel claim—even if the rule barring estoppel claims against government entities is set aside—because Petitioners rely on SPDs that merely described the benefits provided to Health Benefits Program members at the time and did not make promises about the future. Pet. ¶¶ 248-54. However, to the extent that Petitioners purport to rely on statements by "City officials and human resources officers" or others who "verbally assured employees" regarding their health insurance benefits, and might have incorrectly gone beyond the declarations in the SPDs by offering forward-looking guarantees, this still cannot support Petitioners' promissory estoppel claim. *See id.* ¶ 260.

This is because "[e]rroneous advice by a government employee does not constitute the type of unusual circumstances" warranting an "exception to th[e] general rule" barring the application of the doctrine of estoppel against government entities. *Caldwell v. New York City Tr. Auth.*, 972 N.Y.S.2d 142, 142 (Sup. Ct. N.Y. Cnty. 2013) (Stallman, J.) (internal brackets omitted); *see also Keep Food Legal v. New York City Dept. of Health & Mental Hygiene*, 2014 NY Slip Op 30359(U), 5 (Sup. Ct. N.Y. Cnty. Feb. 10, 2014) (Kern, J.) (citing *Matter of Cahill (Rowan Group, Inc. v. Commissioner of Labor*, 79 A.D.3d 1514, 1514-15 (3d Dept 2010)) ("[I]t has long been held that estoppel is unavailable against a government agency except in extraordinary circumstances, and receiving misinformation from a government employee does not constitute such a circumstance.").[3] In *Westmorland v. New York State and Local Retirement System*, the court

[3] Additionally, erroneous advice by a government official would not bind the City even outside of the estoppel context:

> A long, impressive line of cases beginning with *McDonald v. Mayor* (68 N.Y. 23) has firmly established as fundamental the principle that one dealing with a municipality through its officials must take great care to learn the true nature and extent of their power and authority. *One relies on the self-asserted, naked*

cited this reasoning in its decision denying an Article 78 petition's attempt to apply the doctrine of estoppel against the government based on a government employee's "incomplete or erroneous advice" to the petitioner, a retired typist, regarding her eligibility for public retirement benefits. 129 A.D.3d at 1404. The *Westmorland* court held that estoppel was not available against governmental agencies "except in narrow circumstances not present here," and further held that "estoppel cannot be invoked to create rights to retirement benefits to which there is no entitlement." *Id.* at 1404-05. Petitioners' promissory estoppel claim in this proceeding should be denied for the same reasons.

Petitioners' Brief cites *Robinson v. New York* and *Agress v. Clarkstown Central School District* as examples of cases where an estoppel claim was allowed to proceed against the government because there was wrongful government conduct resulting in "manifest injustice" sufficient to overcome the general rule barring such claims. Br. at 23. But both *Robinson* and *Agress* are inapposite. In *Robinson*, the plaintiff had entered into a written stipulation with the City of New York, at the City Comptroller's request, to adjourn the City's examination of the plaintiff pursuant to section 50-h of the General Municipal Law. 24 A.D.2d 260, 261-65 (1st Dep't 1965). The stipulation provided that the plaintiff could not sue the City until after the adjourned examination, and the City failed to conduct the examination before the expiration of the relevant

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> *representation of an official's power and authority to bind the municipality at one's peril.* It is recognized that this principle has worked hardship in the past and may in the future, but it is a rule of necessity that moral obligations alone cannot bind the municipality since 'no legal obligation arose.'

Steiner Egg Noodle Co. v. City, 63 Misc.2d 163, 165-66 (1st Dep't 1969), *aff'd* 34 A.D.2d 892 (1st Dep't 1970) (emphasis added) (citing *Seif v. Long Beach*, 286 N.Y. 382, 389 (1941)) (reversing judgment against City on fraud claim that was premised on alleged misrepresentation by Commissioner of Public Works to property owners that City would pay for costs of installing sidewalks).

statute of limitations. *Id.* at 261-62. Given this unusual situation that bears no similarity to the circumstances of the instant proceeding, the *Robinson* court equitably estopped the City from asserting the statute of limitations as a defense. *Id.* at 264-65. *Agress* similarly involved an unusual circumstance involving wrongful government conduct. In *Agress*, the plaintiff retiree alleged not only that the defendant school district incorrectly advised her that she was eligible for retirement benefits, but also that the school district in fact incorrectly provided those benefits for several years, in violation of its own benefits eligibility policies. 69 A.D.3d at 770-71. Because *Robinson* and *Agress* both concerned unusual wrongful government conduct not present in this proceeding, both decisions are irrelevant here.

Therefore, while Petitioners have not alleged the existence of a clear and definite promise sufficient to support their promissory estoppel claim, or reliance, or injury, their claim should also be denied under the rule that the doctrine of estoppel is not available against the government.

POINT II

THE CITY'S PLAN TO OFFER AETNA MAP DOES NOT VIOLATE THE MORATORIUM LAW APPLICABLE TO DOE RETIREES

A. The Moratorium Law Was Intended to Prevent Dramatic Changes to Health Insurance Coverage Levels Provided by School District That Are Directed Solely At Retirees

As a threshold point, the Moratorium Law applies only to retirees from school districts, and so only those petitioners who retired from DOE may assert the claim. In any event, the claim lacks merit. The Law prohibits school districts from

> diminishing the health insurance benefits provided to retirees and their dependents or the contributions such board or district make for such health insurance coverage below the level of such benefits or contributions made on behalf of such retirees and their dependents by such district or board unless a corresponding diminution of

> benefits or contributions is effected from the present level during this period by such district or board from the corresponding group of active employees for such retirees.

Chapter 729 of the Laws of 1994 (as amended by L 2009, Ch. 30 and L 2009, ch. 501 § 14). The Law was intended to prevent drastic changes to retiree health insurance benefits provided by school districts that would either decrease the overall level of coverage available to retirees or dramatically increase the portion of health insurance costs borne by retirees. The changes at issue here are far from the dramatic changes this statute envisions. The justification set forth in the Assembly Memorandum in Support of an earlier bill addressing this topic, which was passed by the Legislature but vetoed by the Governor in 1993 (the "1993 Bill"), the year before passage of the first Moratorium Law, provides the relevant context:

> The financial security of thousands of retired public educational employees in New York State is being seriously threatened. An overwhelming majority of these retired public servants are presently without any protection whatsoever from having their health insurance coverage diminished or completely eliminated by public employers who no longer feel an obligation to provide the health insurance to which they agreed at the time of retirement. This legislation is designed to address the growing crisis of providing health care to retirees and their dependents.
>
> Over 35 years ago, the State enacted the State Health Insurance Plan which provides health insurance coverage for all active and retired state employees and their families. Political subdivisions may voluntarily participate in this State Health Insurance Plan and almost all school districts . . . did participate during the early years. As the competition for insurance dollars increased, many of these school districts . . . dropped the State Health Insurance Plan and provided health insurance coverage through private insurance carriers who promised 'better coverage' at a lower cost. However, under these private plans, coverage is not guaranteed for retirees and in many cases not even available for retirees [sic]
>
> In recent years the urge to contain or reduce costs has caused some of these school districts . . . to abandon their longstanding policy of providing health insurance coverage for retirees throughout the retirement years. Currently, there is no statutory requirement for public employers to provide health care coverage to retirees and

> because retirees are not represented in the collective bargaining process, they are powerless to stop the unilateral depreciation or even elimination of health insurance benefits once the contract under which they retired has expired. any changes in the long-standing public policy of providing health insurance coverage for retirees requires careful consideration and full exploration by knowledgeable experts as well as by the affected parties themselves . . .

Assembly Mem in Support, Veto Jacket, 1993 Veto No. 63. *See* Senate Bill 5880 §1 (1993) annexed as **Ex. 4** to Ans. In other words, the baseline assumption was that most school districts had been providing the same health insurance benefits to active employees and retirees, and the legislature's motivating concern was that retiree coverage would be singled out for drastic reduction or even elimination. The 1993 Bill would have convened a task force to study the issue and imposed a one-year "freeze" on "all health insurance for retired educational employees." Senate Bill 5880; Letter from Office of Labor Relations, Bill Jacket, L 1994, ch 729, annexed as **Ex. 5** to Ans.

Then-Governor Mario M. Cuomo vetoed the 1993 Bill because it did not allow school districts any flexibility to change retirees' benefits based on fiscal concerns. Governor's Disapproval Mem, Veto Jacket 1993 Veto No. 63, annexed as **Ex. 4** to Ans. The Governor explained that the proposed law would "impose a new, unfunded mandate on school districts and would interfere with their ability to establish spending priorities" by requiring districts to maintain retirees' benefits "without regard to existing budgets, increasing costs, or actions taken with respect to health insurance for active employees."[4] *Id.*

[4] The Law was originally intended as a short-term measure, pending the issuance of further recommendations by the task force. *See Matter of Bryant v. Board of Educ.*, 21 A.D.3d 1134, 1138 (3d Dep't 2005) (explaining that Law was "designed as a short-term effort to maintain the status quo while a comprehensive solution was developed [but instead] has … slipped into the long-term policy"). Later, annual "clones of the 1994 statute" were enacted (*id.* at 1135), and then the Law was made "permanent" in 2009 (Governor's Mem at 5, Bill Jacket, L 2009, ch 504, annexed as **Ex. 6** to Ans.).

The following year, the first Moratorium Law was enacted. It arose out of the same concern as the prior bill, that "[u]nexpected changes to health insurance coverage can have a dramatic impact on one's ability to afford adequate coverage" (Governor's Approval Mem, Bill Jacket, L 1994, ch 729, annexed as **Ex. 5** to Ans.) and had the same goal of preventing "dramatic changes to their [retirees'] benefit levels" (Budget Div. Approval Mem, Bill Jacket, L 1994, ch 729, **Ex. 5** to Ans.), but employed a modified approach that allowed school districts the flexibility to make changes to retiree health benefits as long as "corresponding" changes were made to benefits for active employees." The Law sought to "insulate[]" retirees from "dramatic changes to their benefit levels" by tying retiree benefits to benefits for active employees, which are subject to collective bargaining. Budget Division Approval Mem, Bill Jacket, L 1994, ch 729, **Ex. 5** to Ans.; *see Bailenson v. Bd. of Educ.*, 194 A.D.3d 1039, 1041 (2d Dep't 2021) (explaining that "purpose" of Law "was to tie retiree benefits to active employee benefits so that retirees could benefit from the collective bargaining power of the active employees").

It is clear from this history that the Moratorium Law was not intended to require school districts to maintain the same health insurance plan, or the same itemized components of coverage, for retirees ad infinitum, regardless of changes to the healthcare market and budgetary realities. Nor was it intended to prevent districts from achieving costs savings that would allow them to maintain the same level of coverage for retirees while reducing the amounts expended. Specifically, the context in which the Law was enacted—in which most districts were apparently presumed to be providing health insurance by paying some or all of the premiums for coverage under the State Health Insurance Plan—makes clear that the Law's reference to "contributions" was intended to refer to the proportion of health insurance premiums borne by district and not to the dollar amount expended. In other words, the goal was to prevent school districts from shifting

substantially more of the cost of those premiums to retirees. Moreover, interpreting the Law to prevent plan redesign and renegotiation for cost savings would render it in conflict with the States' competitive bidding laws, which require school districts, like other government entities, to foster competition among prospective contractors and to seek "to facilitate the acquisition of high quality goods and services at the lowest possible cost" (*Associated Gen. Contractors v. N.Y. State Thruway Auth.*, 88 N.Y.2d 56, 67, 68 (1996)). Such an interpretation would lead to absurd and unreasonable results—freezing health insurance plans in perpetuity without regard for innovation or increased efficiency—and therefore must be rejected. *See Anonymous v. Molik*, 32 N.Y.3d 30 (2018) (statute should be interpreted to "effectuate the intent of the Legislature" and to avoid "absurd or unreasonable consequences") (quoting *Patrolmen's Benevolent Assn. v. New York*, 41 N.Y.2d 205, 208 (1976); *Auerbach v. Board of Educ.*, 86 N.Y.2d 198, 204 (1995)); *Long v. Adirondack Park Agency*, 76 N.Y.2d 416, 420 (1990) (interpreting statute to reach "sensible and practical over-all construction, which is consistent with and furthers its scheme and purpose . . .").

B. The Courts Have Interpreted and Applied the Law in a Manner Consistent with Its Purpose

Consistent with the legislative purpose set forth above, courts have interpreted the Moratorium Law to prevent school districts from making changes to retiree health insurance that diminished benefits either by substantially reducing the level of benefits provided to retirees or by increasing the portion of health insurance premiums borne by retirees, when corresponding changes to health insurance benefits for active employees are not, or have not been, made. For example, in *Anderson v. Niagara Falls City Sch. Dist.*, 125 A.D.3d 1407 (4th Dep't 2015), the Court found a violation where the school district made a "substantial reduction in health insurance benefits" for retirees during the same period that it made an "improvement" in health insurance benefits for active employees. And in *Perrotta v. Syosset Cen. Sch. Dist.*, 210 A.D.3d 986 (2d

Dep't 2022), the Court found a violation where the school district reduced the percentage of the cost of the premium for the State Health Insurance Plan that it paid for retirees to 50% (meaning retirees had to pay the remaining 50% of the premium) while continuing to pay 80% of the premium for active employees. *See also Jones v. Board of Educ.*, 30 A.D.3d 967 (4th Dep't 2006) (finding violation where school district reduced its contribution to premiums for retirees by 10% and reduced its contribution to premiums for active employees by only 4%). And several cases have found violations where school districts ceased reimbursing retirees for Medicare premiums and/or surcharges, effectively increasing the portion of premiums borne by retirees. *Bailenson*, 194 A.D.3d 1039 (school district ceased reimbursement of surcharge on Medicare Part B premiums); *Baker v. Board of Educ.*, 29 A.D.3d 574 (2d Dep't 2006) (school district ceased reimbursement of Medicare Part B premiums); *Bryant v. Board of Educ.*, 29 Misc.3d 706 (Broome Co. 2010) (same); *see also May v. Board of Educ.*, 2008 N.Y. Misc. LEXIS 10256, *5 (Wayne Co. Oct. 24, 2008) (finding violation where district ceased paying premiums for traditional indemnity plan and ordering that retirees pay no more than same percentage of premiums as active employees). None of these cases addressed the situation presented here, in which the City will continue to pay the full premium and provide comprehensive health benefits to retirees by transitioning retirees from a premium-free supplemental insurance plan to a premium-free MAP.

No violation of the Moratorium Law exists, however, where—as here—changes to retiree benefits have not exceeded changes to benefits for active employees. *Altic v. Board of Educ.*, 142 A.D.3d 1311, 1312 (4th Dep't 2016) (finding no violation where corresponding change to prescription benefits had been made to plan for active employees before change was applied to retirees). And those corresponding changes need not be made at the same time, as courts have repeatedly made clear. *See id.; Jones v. Board of Educ.*, 30 A.D.3d 967, 969 (4th Dep't 2006)

(affirming trial court's finding of moratorium law violation but explaining that "[w]e disagree with the [trial] court's reasoning . . . that the relevant time period during which the District may diminish contributions on behalf of retirees with a corresponding diminution of contributions on behalf of active employees is limited to a one-year period"). And, importantly, the Law "does not require that the exact same benefit be taken from both groups" (*Bryant*, 29 Misc. 3d at 709) but only that a "similar" change be made to both groups.

The contrary approach suggested by petitioners would make no sense: it would penalize school districts that endeavor to avoid making changes to retiree health care even as they adjust the health care benefits of active employees—an approach that not only honors but goes beyond the Moratorium Law's purpose. And it would create nearly irresistible incentives for school districts to make corresponding adjustments to retiree health coverage in lockstep each and every time they adjust coverage for active employees, lest they lose their only opportunity to do so.

C. The City's Implementation of the Aetna MAP Does Not Violate the Moratorium Law

Petitioners' allegation that the City's implementation of the Aetna MAP violates the Moratorium Law as to DOE retirees by "diminishing its healthcare contributions for Retirees without a corresponding diminution for active employees" (Br. at 41) is based on a misunderstanding of the purpose and application of the Law. As set forth above, the Law is intended to prevent drastic changes to benefits directed solely at school district retirees, not to prevent school districts from achieving cost savings. Thus, "the effect on the employer," whether in the form of cost-savings or otherwise, "is not relevant to the determination" of whether the Law has been violated. *Bryant*, 29 Misc. 3d at 708. Rather, this determination must be based solely on

a comparison of "the effect of any changes on the retirees" to "the effect of any changes to comparable benefits or contributions provided to a corresponding group of active employees." *Id.*

Petitioners cannot demonstrate that implementation of MAP will lead to an overall "diminution" in the level of benefits provided to DOE retirees because Petitioners do not present a comprehensive comparison of the benefits provided under MAP with the previously available retiree plans. *See Bryant*, 21 A.D.3d at 1137-38 (reversing trial court's decision finding violation and remanding for further consideration where petitioners failed to present sufficient details concerning the impact of the challenged policy changes); *cf. Anderson v. Niagara Falls City Sch. Dist.*, 125 A.D.3d 1407, 1409 (4th Dep't 2015) (holding petitioners "met their burden of establishing the unlawful reduction of their benefits" where they supplied affidavit from expert along with specific comparison of benefits). Petitioners do not account for the ways in which the Aetna MAP will improve upon the Senior Care plan, including by applying a lower deductible of $150 (compared to the $276 deductible that currently applies to the Senior Care plan[5]), imposing a cap on out-of-pocket expenses (which Senior Care does not have), and offering additional benefits not available under Senior Care, such as transportation to certain medical appointments, fitness programs and wellness incentives. *See* Aetna's Proposed Verified Answer, NYSCEF Doc. No. 68, at ¶ 417; Plan Comparison Chart annexed to Affidavit of Karl Geercken, NYSCEF Doc. No. 63; Aetna Information Kit annexed to Affidavit of Karl Geercken, NYSCEF Doc. No. 65. Petitioners' claim fails on this basis alone.

Petitioners' allegations also do not account for the fact that New York City was differently situated from the majority of school districts to which the Law was apparently directed

[5] This amount comprises a deductible imposed under Medicare Part B, which is currently $226 but is subject to annual adjustment, and a $50 is a deductible imposed by Senior Care. *See* Ans. ¶ 429.

because New York City did not participate in the State Health Insurance Plan and coverage for NYC retirees was, at least in some respects, more comprehensive than coverage for active employees, who were already charged co-pays for some services and subject to prior authorization requirements for others, when the Law was introduced in 1994. Ans. ¶ 410. Given this different context, a more nuanced application of the Moratorium Law is appropriate.

Nor do their allegations account for the fact that corresponding changes have been made to health insurance benefits for active employees—eliminating this matter from the scope of the Moratorium Law. *Cf. Altic*, 142 A.D.3d 1311 (finding no violation where comparable change had already been made to benefits for active employees). Even assuming arguendo that the transition to the Aetna MAP could be seen as diminishing the level of benefits, active employees have already been subjected to a "corresponding diminution." As set forth below, many of the changes Petitioners point to here—like co-pays—have long been a part of the plans for active employees.

As explained in the Proposed Answer of the Municipal Labor Committee, which negotiates changes to retiree benefits, the "MLC has always endeavored to protect retirees . . . opt[ing] . . . to first make changes and find efficiencies within the active/pre-65 retiree plans before looking to Medicare-retiree plans." MLC's Proposed Answer and Exhibits ("MLC Ans."), NYSCEF Doc. No. 80, ¶ 424; *see* ¶¶ 406-409, 454-55. Therefore, NYC retirees have long enjoyed the benefit of having their benefits "tie[d] . . . to active employee benefits so that retirees . . . benefit from the collective bargaining power of the active employees," *Bailenson*, 194 A.D.3d at 1041; *see* ECF No. 80 ¶417.

Disregarding courts' guidance to take an over-all approach to the Moratorium Law, Petitioners focus on four individual changes that they contend demonstrate impermissible

diminutions in coverage, but even those specific changes do not make out a Moratorium Law claim, as discussed below.

Co-Pays

Petitioners' arguments that the introduction of $15 co-pays for certain medical services establishes a violation of the Moratorium Law because "co-pays for active employees will remain the same" (Br. at 43) reflects a misunderstanding of the Law. As set forth above, evaluation of whether there have been corresponding changes to coverage for active employees is not limited to concurrent changes. *See Jones*, 30 A.D.3d at 969. In this case, corresponding changes to the health insurance plan covering the majority of active employees preceded the current changes for retirees, consistent with the Legislature's intent that retirees not be singled out for coverage changes.

Specifically, with respect to specialist visits, co-pays for active employees under the GHI-CBP were increased on April 1, 2004, from $10 to $20, and again on July 1, 2016, from $15 to $30.[6] MLC Ans. ¶ 454 & Ex. 4, NYSCEF Doc. No. 80 at pp. 121-22. This $20 overall increase more than offsets the $15 increase for retirees. Likewise, the addition of a $15 co-pay for complex radiology, X-rays and lab tests for retirees is more than offset by increases to active employees, who saw such co-pays increase from $10 to $15 in 2004, and then again in 2016, from $15 to $20 for regular diagnostics and $15 to $50 for complex radiology. *See id.* Therefore, the introduction of co-pays does not establish a violation. *See Altic*, 142 A.D.3d 1311 (finding no violation where reduction of benefit for retirees followed an earlier corresponding reduction to benefit for active employees). While Petitioners point to the availability of certain "preferred"

[6] In 2016, co-pays for specialists affiliated with a particular network, which are located in New York City and Nassau and Suffolk Counties, were eliminated under the GHI-CBP. *See* Ans. ¶ 411.

providers to which co-pays do not apply under GHI-CBP and certain other plans for active employees, the existence of these limited alternatives does not negate the changes applicable to the majority of providers. Notably, certain providers are also exempt from co-pays under the HIP VIP plan that is available to retirees in New York City, Nassau, Suffolk, Westchester, Rockland and Orange Counties, a larger geographic reach. *See* Ans. ¶ 411.

Prescription Drug Benefits

Petitioners' claims of diminution based on changes to the prescription drug rider also fail. Petitioners' assertion that the Silver Script plan offers a lesser benefit because "the cost of drugs under the Aetna SilverScript is generally much higher than the cost of drugs under the Senior Care Drug Rider . . ." (Br. at 45; Pizzitola Aff. ¶ 33) appears to be based solely on anticipated increases in the price of five individual drugs selected from the thousands of drugs covered under the SilverScript plan.[7] Petitioners do not proffer any comprehensive analysis supporting their conclusory claim that costs will "generally" increase, or indicating that coverage levels will decrease, for retirees overall.[8] *See Kolbe v. Tibbetts*, 22 N.Y.3d 344, 356 (2013) (explaining that evaluation of whether health insurance coverage was "equivalent" for purposes of compliance with collective bargaining agreement, should focus on examination of relevant changes "for their effect on the class of retirees as a whole, to determine if they have significantly

[7] One of the five drugs is not identified by name. Bollacke Aff., NYSCEF Doc. No. 6, at ¶ 5. It appears that two of the drugs—Jakafi and Trulicity—were not approved until well after the enactment of the Moratorium Law, which highlights the irrelevance of individual drug prices to this analysis. *See* https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202192s023lbl.pdf; https://www.accessdata.fda.gov/drugsatfda_docs/nda/2014/125469Orig1s000TOC.cfm#:~:text=Approval%20Date%3A%209%2F18%2F2014.

[8] Nor do Petitioners provide any support for the conclusory assertion that "[t]here has been no comparable increase in prescription drug costs for active employees." Pizzitola Aff., NYSCEF Doc. No. 5, at ¶ 33.

reduced their general level of benefits . . . rather than evaluating any net cost increases or diminished benefits for individual plaintiffs in isolation") (quoting *Poole v. Waterbury*, 266 Conn. 68, 105 (2003); *Diehl v. Twin Disc, Inc.*, 102 F.3d 301, 311 (7th Cir. 1996)). Aetna Silver Script covers all Part D drugs as well as additional supplemental drugs. MLC Proposed Answer Ex. 13 (ECF No. 80 pp. 216-19). And while the Senior Care rider requires 25% coinsurance for all drugs, Silver Script does not require any coinsurance for common preferred generic drugs obtained through its pharmacy networks (including CVS) or by mail order. *Id.*

While the 2024 monthly cost of the optional Silver Script rider will present a $10 increase from the $125 cost of the 2023 Senior Care rider, this change will have no effect on the many retirees who receive prescription benefits through union welfare funds or are reimbursed for the cost of a drug rider. *See* MLC. Ans., NYSCEF Doc. No. 80, at ¶ 470. And this change does not constitute a diminution for purposes of the Moratorium Law because retirees already bore the full cost of prescription drug coverage—there has been no diminution in the City's "contribution." Nor does the change in price constitute a diminution in "benefits"—as those are distinct concepts. The drug rider prices charged by Senior Care have gone up a number of times over the years (Ans. ¶ 468)—as prices typically do—without creating any Moratorium Law problem. The outcome here is no different. Petitioners' claim that the unavailability of a choice of drug riders constitutes a diminution is addressed below.

Choice of Plans

Petitioners' novel argument that the mere reduction or elimination of choice of health insurance plans constitutes a "diminution of benefits" for purposes of the Moratorium Law must be rejected as it finds no support in the plain language of the Law. A health insurance benefit is commonly understood to refer to an item or service covered under a plan. *See*

healthcare.gov/glossary/benefits (defining "benefits" as "[t]he health care items or services covered under a health insurance plan"). The option to select from multiple health insurance plans providing such health insurance benefits, while perhaps preferable from the perspective of an insured, cannot be reasonably understood to be a health insurance benefit, in and of itself.[9] Notably, while Petitioners appear to place a high premium on choice, the vast majority of retirees (approximately 95%) currently participate in either Senior Care or HIP VIP. Ans. ¶ 423.

To the extent Petitioners contend that the absence of choice will necessarily result in access to a smaller pool of providers, this contention is based on faulty assumptions and incomplete data. Petitioners' assertion that "many medical providers will not accept the Aetna MAP" (Br. at 46) appears to be based on affidavits from individual retirees that purport to recount conversations with specific medical providers who either disclaimed coverage or expressed uncertainty as to coverage, but fail to identify the providers by name, rendering the claims unverifiable. *See, e.g.*, Reed Aff., NYSCEF Doc. No. 6, ¶ 6 (stating that affiant's unidentified ophthalmologist "does not accept Medicare Advantage programs"); Puma Aff., NYSCEF Doc. No. 6, at ¶ 9 (stating that affiant "asked several [unidentified] doctor's billing offices if they will accept the Aetna [MAP] and they replied that they did not yet know").

[9] As this Court has recognized, the City has never been under any obligation to offer retirees a choice of plans. Decision + Order On Motion, *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 2022 N.Y. Misc. LEXIS 1042, *4 (N.Y. Co. Mar. 3, 2022) , *aff'd*, 210 A.D.3d 559 (1st Dep't 2022), *lv. granted* ____ N.Y.3d _____ (2023). The City had been prepared to allow retirees who opted out of the MAP to remain in Senior Care, but was forced to rescind that option when Petitioners successfully challenged the changes to Senior Care that would have made it viable for the City to offer both plans. *See id.* The City's motion for leave to appeal that decision was recently granted. *Decision List*, NEW YORK STATE COURT OF APPEALS, June 13, 2023, at 11, https://www.nycourts.gov/ctapps/Decisions/2023/Jun23/DecisionList061323.pdf.

Aetna reports, by contrast, that at least 97% of providers who accepted the Senior Care plan have indicated that they will accept the Aetna MAP.[10] Aetna's Proposed Verified Answer, NYSCEF Doc. No. 68, ¶ 417. And Petitioners' glib and wholly conclusory assertion that active employees "will continue to enjoy uninterrupted access to their doctors" (Br. at 46) ignores that changes in professional affiliations and policies regarding acceptance of insurance are commonplace, meaning that no insurance plan can ever guarantee continued access to all providers.

Prior Authorization

As an initial matter, the introduction of a very limited requirement to obtain prior authorization for certain items or services may be a difference in procedure but it is not a reduction in "benefits" within the meaning of the Moratorium Law because it does not change the scope of items or services covered. This distinction is underscored by the claims data submitted by Aetna. *See* Affidavit of Richard Frommeyer in Support of Proposed Intervenor Aetna's Motion ("Frommeyer Aff."), NYSCEF Doc. No. 69, ¶ 86. In any event, Petitioners concede that "health insurance plans for active employees have long required prior authorization for certain services" but contend that the City would violate the Moratorium Law by introducing similar requirements for retirees because there is no further "diminution" currently being effectuated for active employees.[11] Br. at 47. This argument ignores the baseline assumption at the root of the

[10] Aetna explains that this figure includes providers in its MAP network (88% of the providers) in the Aetna MAP network, providers who are not contracted with Aetna but have accepted payment from Aetna (comprising another 8.3%), and hundreds of other providers who have indicated in discussions with Aetna that they will accept the Aetna MAP. Additionally, Aetna reports that there are certain service providers, including Memorial Sloan Kettering, that have signed network contracts with Aetna specifically for the Aetna MAP for NYC Retirees (as opposed to signing a network contract with Aetna for all of Aetna's MAP programs nationwide). *Id.*

[11] Petitioners appear to overstate the scope of the prior authorization requirements. Aetna indicates that it has waived 85% of its typical prior authorization requirements for this plan, and that prior

Moratorium Law, that health insurance coverage provided to active employees was generally equivalent to, if not superior to, coverage provided to retirees. *See* Senate Bill 5880 § 1; *Anderson*, 125 A.D.3d at 1408 (explaining that "baseline" or "floor" for retiree health benefits under Law is "measured by the health insurance benefits received by active employees," and that Law "does not permit an employer to whom the statute applies to provide retirees with lesser health insurance benefits than active employees"). Application of the Law to this situation, in which retiree coverage was previously superior to active coverage in that prior authorization was not required for retirees, and is now being adjusted to bring it into line with, rather than below, the "baseline" represented by benefits for active employees, would present a substantial, and unwarranted, expansion of the Law.

POINT III

PETITIONERS FAIL TO MAKE A CLAIM FOR DANGEROUS DISRUPTION IN LIFE-SAVING TREATMENT

Petitioners argue in their third cause of action that the implementation of the Aetna MAP is arbitrary and capricious and an abuse of discretion because retirees "will face a dangerous disruption in life-saving medical care." *See* Pet. ¶¶ 305-11. Petitioners fail to support this argument with any substantive support and this claim should be denied. Additionally, Respondents adopt and incorporate the arguments set forth in Proposed Intervenor Aetna's Memorandum of Law in connection with Petitioners' third cause of action. *See* Proposed Intervenor Aetna's Memorandum of Law ("Aetna MOL"), NYSCEF Doc. No. 77, at 13-15.

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authorizations will only be required for a limited set of items/services, such as pre-service inpatient hospital stays, rehabilitation facility stays, long-term acute facility stays, skilled nursing facility care, cosmetic procedures; new drugs, therapies, and technologies; and experimental and investigational procedures. NYSCEF Doc. No. 68, ¶ 417.

First, Petitioners claim that they will be denied access to providers who will not accept the Aetna MAP. This argument is made without any support or reference to any providers who claim they will not accept Aetna MAP. Upon receiving a list of providers that retirees receive treatment from and who accept Senior Care, Aetna analyzed and concluded that at least 97% of providers who accepted Senior Care have indicated they will accept payment from Aetna, including the 88% of providers in the Aetna MAP network, the 8.3% of providers who are not contracted with Aetna but have accepted payment from Aetna and the other hundreds of providers who have indicated in discussions with Aetna that they will accept the Aetna MAP. *See* Aetna MOL at 13; *see also* Affidavit of Richard Frommeyer in Support of Proposed Intervenor Aetna's Motion ("Frommeyer Aff."), NYSCEF Doc. No. 69, ¶¶ 65-75.

Aetna has been working with retirees so that they understand the breadth of coverage offered by the Aetna MAP. *See* Aetna MOL at 14. The majority of Petitioners' affidavits do not name specific providers to which Aetna could verify coverage but where retirees have identified providers who do not accept the Aetna MAP, it is working with retirees and providers to develop plans of care and coverage. *See id*. Accordingly, it is untrue where Petitioners claim that they will be denied access to their doctors from whom they receive life-saving care if they choose to enroll in the Aetna MAP. Rather, at least 97% of providers who accept Senior Care have indicated they will accept payment from Aetna and Petitioners will have continuity of care. *See supra*, n. 10.

Second, Petitioners erroneously claim that retirees who choose to waive coverage under the Aetna MAP and seek Medigap coverage on the open market will be denied. Federal and state regulations provide protections for those shopping for Medigap plans on the open market. Retirees who are aged 65 or older who lose coverage by choosing to waive coverage under a

Medicare Advantage plan will have a guaranteed issue to a Medigap plan or other supplemental coverage on the open market, regardless of preexisting conditions. For retirees who are under the age of 65 and Medicare-eligible, 36 states have explicitly extended Medigap coverage protections through guaranteed issue to a Medigap plan on the open market. *See* Aetna MOL at 14; *see also* Affidavit of Stephen Fisher in Support of Proposed Intervenor Aetna's Motion ("Fisher Aff."), NYSCEF Doc. No. 70.

Third, Petitioners also fail to argue that retirees will be subject to high co-pays and prescription drug prices. Aetna MAP does not charge co-pays for primary care visits and for many other services. *See* Aetna MOL at 15; *see also* Frommeyer Aff. ¶ 95. Aetna MAP's prescription drug rider also covers all approved drugs for seniors, many of which are offered at substantial savings to retirees. All Tier 1 generics at preferred pharmacies and mail order services are also offered to members for free. *See* Frommeyer Aff. ¶ 97-100.

Lastly, Petitioners highly misclassify the prior authorization requirements under the Aetna MAP and falsely claim that prior authorizations will cause harm to Retirees. Prior authorization requirements are standard and used in many Original Medicare plans, Medicare Advantage plans and other commercial healthcare plans to ensure that members receive appropriate treatment. *See* Aetna MOL at 15; see also Moffitt Aff. ¶ 6. Aetna, through negotiations with the City and the MLC, has waived 85% of its typical prior authorization requirements. Any changes to the list of services that require prior authorizations must be approved by the City and the MLC. Prior authorizations under the Aetna MAP are required only for the following services: non-emergency inpatient hospital stays, rehabilitation facility stays or long-term acute facility stays, and skilled nursing facility care, as well as certain services/items, like cosmetic procedures;

certain Part B and Part D drugs, new drugs, therapies, and technologies; and experimental and investigational procedures. *See* Aetna MOL at 15.

Petitioners fail to show that Respondents were arbitrary and capricious and abused their discretion when making implementation decisions for the Aetna MAP. Petitioners also fail to show that they will suffer irreparable harm as a result of the Aetna MAP.

POINT IV

PETITIONERS FAIL TO STATE A CLAIM FOR MISSING AND INACCURATE INFORMATION IN VIOLATION OF CPLR 7803

Petitioners erroneously argue that the City has negligently misrepresented the Aetna MAP and made misleading and inaccurate statements about their medical providers and the process for waiving or opting out of the Aetna MAP. Respondents hereby adopt and incorporate the arguments set forth in Proposed Intervenor Aetna's Memorandum of Law in connection with Petitioners' fourth cause of action. *See* Aetna MOL at 16-17.

Additionally, the City, through the New York City Office of Labor Relations' ("OLR") website, posted numerous resources and continues to post relevant, up-to-date information regarding the Aetna MAP. *See* OLR website, https://www.nyc.gov/site/olr/health/retiree/health-retiree-responsibilities-assistance.page. OLR posted a multitude of literature online regarding the Aetna MAP. *See* Ans. ¶ 482.

POINT V

PETITIONERS' SECTION 12-126 CLAIM MUST FAIL BECAUSE THE CITY CAN SATISFY ITS OBLIGATIONS TO RETIREES UNDER SECTION 12-126 BY PROVIDING MEDICARE ADVANTAGE COVERAGE

A. Both the Plain Language and Legislative History of Section 12-126 Show That It Does Not Guarantee a Choice of Multiple Plans

Administrative Code § 12-126(b)(1) ("Section 12-126") provides in relevant part that "[t]he city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis." Section 12-126 defines "Health insurance coverage" in the singular as "[a] program of hospital-surgical-medical benefits." § 12-126(a)(iv). There is nothing in the text of Section 12-126 that guarantees Retirees a choice of more than one health insurance plan, and Petitioners do not claim otherwise.

In matters of statutory construction, "[t]he primary consideration . . . is to ascertain and give effect to the intention of the Legislature." *People v. Santi*, 3 N.Y.3d 234, 243 (2004). The inquiry begins with the statutory text—"the clearest indicator of legislative intent"—and also considers the law's "spirit and purpose," as illuminated by its context and legislative history. *Albany Law School v. N.Y.S. Off. of Mental Retardation & Dev. Disabilities*, 19 N.Y.3d 106, 120 (2012) ("[T]he failure of the Legislature to include a matter within the scope of an act may be construed as an indication that its exclusion was intended." N.Y. Stat. Laws § 74 (McKinney) (Construction and Interpretation); *see also N.Y.C. Campaign Fin. Bd. v. Ortiz*, 38 A.D.3d 75, 83 (1st Dep't 2006) ("This Court cannot by implication supply in § 3–710(2)(b) a provision that, we might reasonably suppose, the City Council intended to omit."). Thus, Section 12-126's silence

regarding the number of health plans that the City must offer precludes any finding that Section 12-126 does impose such a requirement.

Nevertheless, Petitioners argue that Section 12-126's early legislative history demonstrates that it was intended to give Retirees "a choice of health plans." Pet. ¶ 233. Because some Retirees will only have the option of the Aetna Medicare Advantage plan if the City replaces insurance which supplements benefits provided by Medicare with Medicare Advantage, Petitioners allege, Respondents are violating Section 12-126's requirement that the City offer a choice of health plans. *Id.* ¶¶ 20, 321. Petitioners acknowledge that "Retirees who live in the City or in Nassau, Suffolk, Rockland, Orange, or Westchester Counties" will still have a choice of multiple plans, as they "have the option of enrolling in an existing Medicare Advantage plan called HIP VIP." Pet. ¶ 20.

Petitioners specifically cite a 1965 Resolution of the City's Board of Estimate, along with a 1965 letter from then-Mayor Robert Wagner, and a 1965 Division of Budget recommendation, which all contemplated the passage of a bill that would provide retired city employees with a choice of health plans. *Id.* ¶¶ 233, 235-36 (citing Gardener Aff, NYSCEF Doc. No. 4, Ex. H at 27-28, 76); Br. at 47 (citing Gardener Aff, Ex. H at 79). But Petitioners also acknowledge that Section 12-126 was not enacted until 1967. Pet. ¶ 233.

In the time between the 1965 documents cited by Petitioners and Section 12-126's 1967 enactment, Mayor Robert Wagner was succeeded by Mayor John Lindsay, who vetoed the City Council's first attempt to pass a bill codifying the City's obligation to provide retirees with health benefits. Gardener Aff, Ex. H at 8. Mayor Lindsay objected that the initial bill, which would require the City to pay "the entire cost of any basic health insurance plan," bound the City to obligations that were too broad and ill-defined. *Id.* The language was then revised to the current

text which requires only that the City pay "the entire cost of health insurance coverage," without any discussion of multiple options. *Id.* at 9.

Petitioners note that the final language of Section 12-126 is very similar to some of the language used in the 1965 Resolution of the City's Board of Estimate, and that the 1965 Resolution did explicitly discuss granting retired employees "a choice of health plans." Pet. ¶ 236 (citing Gardener Aff, Ex. H at 27). The Resolution specified that the "choice of plans" would include the options of "H.I.P.-Blue Cross, G.H.I. Blue Cross and Blue Cross-Blue Shield-Major Medical," and separately provided that the City would assume "full payment for choice of health and hospital insurance, not to exceed 100 per cent of the full cost of H.I.P.-Blue Cross (21-day plan) on a category basis." Gardener Aff, Ex. H at 24, 27. But the fact that the final version of Section 12-126 is patterned so closely on certain parts of the text of the 1965 Resolution, yet did not include any of the 1965 Resolution's language regarding "a choice of health plans," indicates that the legislature omitted that language deliberately. Thus, even if the City contemplated granting Retirees a choice of health plans in 1965, by the time the City Council enacted Section 12-126 in 1967, they did not intend to codify any such requirement into local law.

Petitioners cite this Court's recent *New York City Organization of Public Service Retirees v. Campion* decision in support of their argument that Section 12-126 guarantees Retirees a choice of plans. Br. at 15 (citing *N.Y.C. Org. of Pub. Serv. Retirees, Inc v. Campion*, 2022 N.Y. Misc. LEXIS 1042 (Sup. Ct. N.Y. Cnty. Mar. 3, 2022), *aff'd*, 210 A.D.3d 559 (1st Dep't 2022), *lv. granted* __ N.Y.2d ___ (2023)). The *Campion* decision enjoined the City from giving Retirees the option of remaining enrolled in insurance which supplements benefits provided by Medicare if they pay premiums, even if the City at the same time provides Retirees with a premium-free Medicare Advantage plan. *Id.* at *3-4. But the same decision further held, "none of this is to say

that the [City] must give retirees an option of plans . . . ; only that if there is to be an option of more than one plan, that the respondent may not pass any cost of the prior plan to the retirees." *Id.* at *4.[12] Therefore, this Court's *Campion* decision does not support Petitioners' interpretation of Section 12-126, and in fact refutes it.

Thus, the Court must reject Petitioner's argument that Respondents are violating Section 12-126 by replacing insurance which supplements benefits provided by Medicare with Medicare Advantage.

B. Section 12-126 Does Not Require the City to Provide a Medigap Plan

The word "cost" in Section 12-126 refers specifically to healthcare premiums, *i.e.* the amounts that an insured pays in exchange for insurance coverage. *N.Y. 10-13 Ass'n v. City of N.Y.*, No. 98 Civ. 1425 (JGK), 1999 U.S. Dist. LEXIS 3733, at *35-38 (S.D.N.Y. Mar. 29, 1999) (holding that the legislative history of Section 12-126 makes clear "that the drafters . . . considered 'cost' to be the equivalent of 'premium'"). Thus, by paying for 100% of the Retirees' Medicare Advantage premiums, the City can satisfy its obligation to "pay the entire cost of [Retirees'] health insurance coverage." N.Y.C. Admin. Code § 12-126(b)(1).

But Petitioners contend that because the federal government helps fund Medicare Advantage Plans—by paying the insurers a subsidy "based on the healthcare needs" of each Medicare Advantage enrollee—the City cannot satisfy its Section 12-126 obligation to pay the "entire cost" of health coverage through Medicare Advantage, and must offer Medigap. Br. at 30; Pet. ¶ 130. Petitioners' argument is not supported by any precedent and is inconsistent with *New*

[12] On June 13, 2023, the Court of Appeals granted the City's motion for leave to appeal the First Department's order affirming this Court's *Campion* decision. *Decision List*, NEW YORK STATE COURT OF APPEALS, June 13, 2023, at 11, https://www.nycourts.gov/ctapps/Decisions/2023/Jun23/DecisionList061323.pdf.

York 10-13 Association, *supra*, which makes clear that Section 12-126's mandate that the City pay for Retirees' health insurance premiums does not include "all charges associated with obtaining basic hospital-surgical-medical services." 1999 U.S. Dist. LEXIS 3733, at *34-35. Additionally, Petitioners' interpretation of Section 12-126 would compel the absurd conclusion that the City is forbidden from making use of federal Medicare Advantage subsidies, which City taxpayers still fund because they are federal taxpayers too. Courts must not "construe statutes, or rules and regulations of a government agency in such a manner as to thwart the obvious legislative intent and reach absurd and unexpected consequences." *Friedman-Kien v. New York*, 92 A.D.2d 827, 828 (1st Dep't 1983). Accordingly, this Court should reject Petitioners' reading of Section 12-126.

Petitioners further argue that the City cannot satisfy its Section 12-126 obligations by offering Medicare Advantage plans in lieu of Medigap because one of the statutes authorizing Section 12-126, N.Y. State General City Law ("GCL") § 20(29-b), states that the City may reimburse Retirees "for premium charges for *supplementary medical insurance* benefits under the federal old-age, survivors and disability insurance benefit program." Br. at 30-31 (quoting GCL§ 20(29-b)) (emphasis supplied by Petitioners' Brief). Another statute authorizing Section 12-126, GCL § 20(29-a), is written more broadly: it states that the City may contract with insurance companies to provide "health insurance," not just supplementary insurance, "for [Retirees] and their spouses and their dependent children." That is precisely what the City's contract with Aetna does.

Nothing in GCL§ 20(29-b) limits the authorization provided by § 20(29-a). Another part of Section 12-126 not at issue in this proceeding provides that "the City shall reimburse covered employees in an amount equal to one hundred percent of the Medicare Part-B premium rate applicable to that year." N.Y.C. Admin. Code. § 12-126(b)(1). GCL§ 20(29-b), authorizing

the city to "reimburse" premiums paid by retirees under Medicare, appears to have been intended to authorize these Medicare Part B reimbursements. In contrast, the broader GCL§ 20(29-a) allows the City to cover retirees' premiums arising under contracts entered into with private insurers; the City does not "reimburse" those premiums, but rather pays them directly to the insurers.

Nevertheless, because of the narrower language of § 20(29-b), Petitioners assert that the authorizing statutes only allow the City to provide health coverage to Retirees through "Medicare supplemental insurance," meaning Medigap. Br. at 31. Petitioners presume that § 20(29-b)'s authorization of reimbursement for "supplementary medical insurance under" Medicare allows the City to offer Medigap coverage but not Medicare Advantage, because "Medigap coverage supplements original Medicare, while Medicare Advantage is a private insurance alternative to federally run Medicare." Pet. ¶ 129. But Petitioners' interpretation of § 20(29-b) does not stand up to scrutiny when read together with GCL§ 20(29-a), Section 12-126, and historical context. Indeed, as Petitioners allege, "Medicare Advantage did not exist until decades after [GCL § 20(29-b)] was passed," so the legislature could not have intended to bar the City from providing Medicare Advantage coverage. Pet. ¶ 240.

Courts are required to defer to the statutory interpretations "of the [City] agenc[ies] charged with administering the statute." *Chin v. N.Y.C. Bd. Of Stds. & Appeals*, 97 A.D.3d 485, 487 (1st Dep't 2012). And if GCL § 20(29-b) is construed as barring the City from taking advantage of federal Medicare Advantage subsidies, this would be an "absurd and unexpected consequence[]" of the statute. *Friedman-Kien*, 92 A.D.2d at 828. For these reasons alone, this Court should reject Petitioners' effort to read GCL § 20(29-b) as prohibiting the City from providing Medicare Advantage in lieu of insurance which supplements benefits provided by Medicare.

Additionally, this Court has previously considered and rejected a similar attempt to read GCL § 20(29-b) as barring the City from providing benefits that are not explicitly authorized by that statute. *See Slattery v. City of New York*, 686 N.Y.S.2d 683 (Sup. Ct. N.Y. Cnty. 1999) (York, J.), *aff'd* 266 A.D.2d 24 (1st Dep't 1999). The *Slattery* plaintiffs challenged a local law whereby the City provided health coverage to the domestic partners of retirees. *Id.* at 685, 691. Plaintiffs relied on the fact that GCL § 20(29-b) only provides for the reimbursement of health coverage expenses incurred by retirees "and their spouses and their dependent children." *Id.* at 691. However, another relevant authorizing statute, GCL § 92-a, contained broader language allowing the City to provide health coverage to certain retirees "and their families," which created "ambiguity regarding legislative intent." *Id.* at 691-92.

This Court resolved the ambiguity in favor of the City, holding that the power to determine employee compensation, including health insurance benefits, "has been specifically conferred upon local governments by the 'home rule' article (art. IX, § 2) of the New York State Constitution." *Id.* at 691-92 (internal brackets omitted). "In light of the broad grant of power to local governments in this area," the decision continued, "absent absolute conflict with statutory or constitutional authority, the courts should not intervene where the salary and benefits accorded to municipal employees are at issue." *Id.* at 692 (internal citation omitted). Along these same lines, the *Slattery* decision further held that the City should be allowed "flexibility" in interpreting the statutes that authorize the city to provide compensation and benefits to municipal employees. *Id.*

In this proceeding, like in *Slattery*, the City's ability to provide health coverage is authorized pursuant to both the narrowly worded GCL § 20(29-b), and the broadly worded GCL § 20(29-a), which allows the City to contract with companies to provide "health insurance," without qualification as to what type of health insurance. GCL § 20(29-a) thus clearly allows the

City to contract with Aetna to provide Medicare Advantage coverage, while Petitioners' contrary interpretation of GCL § 20(29-b) at most creates ambiguity. For the same reasons that this Court articulated in *Slattery*, the Court here should resolve any ambiguity between GCL §§ 20(29-a) and 20(29-b) in favor of the City, and thereby find that the City is authorized to provide the Retirees with Medicare Advantage Coverage, not just insurance which supplements benefits provided by Medicare.

For all of the above reasons, the City can satisfy its Section 12-126 obligations to Retirees by providing Medicare Advantage Coverage. Therefore, Petitioners' claim for violation of Section 12-126 must be denied.

POINT VI

PETITIONERS WHO ARE UNDER 65 AND MEDICARE-ELIGIBLE FAIL TO STATE A CLAIM FOR VIOLATIONS OF THE NEW YORK STATE HUMAN RIGHTS LAW AND NEW YORK CITY HUMAN RIGHTS LAW

A limited number of petitioners who are under 65 and Medicare-eligible allege disability discrimination based on disparate treatment and disparate impact pursuant to the New York State Human Rights Law ("SHRL") and the New York City Human Rights Law ("CHRL"). The Petition claims that the City discriminates against Medicare-eligible retirees under age 65 or rather, those considered disabled, in accordance with the Medicare guidelines as compared to non-Medicare eligible New York City retirees under age 65, after its decision to discontinue the Senior Care Plan and other Medicare plans and enroll all Medicare eligible retirees and their Medicare eligible dependents into the Aetna Medicare Advantage Plan with the ability to opt-out of the Aetna MAP and enroll in the HIP VIP. As stated further below, the Petition's arguments are unavailing.

A. Disparate Impact

The Petition fails to plead a disparate impact claim. To establish a disparate impact claim, the Petition must allege "[a] facially neutral practice[] fall[s] more harshly on a protected group than on other groups and *cannot otherwise by justified*." *Mete v. N.Y. State Office of Mental Retardation & Developmental Disabilities*, 800 N.Y.S.2d 161, 167-68 (1st Dep't 2005) (emphasis in original). Even under the more lenient standard, the CHRL requires that the policy or practice must result in a disparate impact to "the detriment of any protected group." *Burgis v. City of N.Y. Dep't of Sanitation*, 2018 N.Y. Slip 33322(U), *8 (Sup. Ct. N.Y. Cnty. 2018). To do so, the Petition must allege a causal connection between the policy or practice and the purported disproportionate effect. *See id*. Additionally, as stated, the Petition must raise an inference that the decision "cannot be justified by an explanation other than" discrimination. *Mete*, 800 N.Y.S.2d at 168. The Petition has not done so.

The Petition fails to identify a policy or practice that disproportionality affects New York City Medicare eligible retirees under age 65. *See* Pet. ¶¶ 324-327, 332, 334-337, 342. The City's decision to discontinue the Senior Care and other Medicare plans and enroll Medicare retirees into the Aetna MAP with the option to opt-out of Aetna MAP and enroll into the HIP VIP cannot be reasonable construed as a practice or an ongoing policy, let alone one that persistently disproportionately affected a protected group. *See Williams v. New York City Dep't of Corr.*, 2022 NYLJ LEXIS 380, *5 (Sup. Ct. N.Y. 2022) ("failing to identify any employment practice that had a 'disparate impact' on members of a protected group").

Aetna MAP and HIP VIP will cover all Medicare-eligible New York City retirees and their Medicare-eligible dependents, whether they are considered disabled under Medicare guidelines, or whether they qualify for Medicare coverage because they are over age 65. See Pet.

¶¶ 2-3; *Medicare.gov*, GET STARTED WITH MEDICARE, https://www.medicare.gov/basics/get-started-with-medicare (last visited June 9, 2023); *Office of Labor Relations*, CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIRES, https://www.nyc.gov/site/olr/health/retiree/health-retiree-medicare-eligible.page (last visited June 9, 2023). Therefore, should a retiree or dependent be ineligible for Medicare,, they must select from the different healthcare options available to active, non-Medicare eligible employees. *See Office of Labor Relations*, NON-MEDICARE ELIGIBLE RETIREES, https://www.nyc.gov/site/olr/health/nonmed/health-non-medicare-retiree.page (last visited June 9, 2023). That said, non-Medicare eligible retirees and Medicare-eligible dependents have always had different healthcare options, regardless of the different types of plans. The discontinuance of Senior Care and other Medicare plans and the enrollment of Medicare retirees into Aetna MAP with the option to opt-out of Aetna MAP and enroll into HIP VIP does not change this prior practice.

The Petition claims that because the portion of Medicare eligible retirees under age 65 now must select from a sole premium-free option, they are fundamentally receiving substandard care. In support of this contention, the Petition hinges on the conclusory assertion that Aetna MAP is considered "inferior health insurance coverage," when compared with other plans. *See* Pet. ¶¶ 9, 127, 213, 317, 325, 335, 349. However, Petitioners' reliance on their own misconceptions, misunderstandings, and mischaracterizations are insufficient to demonstrate a causal connection between the City's decision and any purported disproportionate effect. Mere "bottom line" allegations are insufficient to make out disparate claim. *See Burgis.*, 2018 N.Y. Slip 33322(U), *8 (failing to "allege any facts that the defendant's actions" were motived by a protected class); *Adams v. City of N.Y.*, 2021 N.Y. Misc. LEXIS 19055, at *5 (Sup. Ct. N.Y. Cnty. 2021).

Absent from the pleadings are any factual allegations, beyond Petitioners' own interpretation, that the decision to discontinue the Senior Care Plan and other Medicare plans and enroll retirees into the Aetna MAP with the option to opt-out of Aetna MAP and enroll into HIP VIP will have a detrimental effect on Medicare-eligible retirees under age 65 as compared with non-Medicare eligible retirees under age 65. The Petition ignores that disabled individuals who are Medicare eligible before reaching age 65, and those individuals who Medicare eligible that have reached age 65, will be enrolled in identical plans under Aetna MAP with the option to opt-out of Aetna MAP to enroll into HIP VIP. *Compare Office of Labor Relations*, NON-MEDICARE ELIGIBLE RETIREES, https://www.nyc.gov/site/olr/health/nonmed/health-non-medicare-retiree.page (last visited June 9, 2023), *with Office of Labor Relations*, CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES, https://www.nyc.gov/site/olr/health/retiree/health-retiree-medicare-eligible.page (last visited June 9, 2023). Therefore, the decision to enroll Medicare retirees into Aetna MAP with the option to opt-out of Aetna MAP and enroll into HIP VIP cannot have a disparate impact on New York City retirees with disabilities. Moreover, the enrollment of Medicare retirees into the Aetna MAP with the option to opt-out of Aetna MAP to enroll in HIP VIP on a subset of retirees with disabilities, and "not the entire protected class, . . .[does] not qualify as [a] disparate impact . . . cause of action." *Bennet v. Time Warner Cable, Inc.*, 2014 N.Y. Slip Op 33007(U), *12 (Sup. Ct. N.Y. 2014).

Even so, the Petition fails to challenge the Aetna MAP's specific application to Medicare-eligible retirees under age 65 as compared with non-Medicare eligible retirees to suggest that there is indeed a causal connection between the City's decision to enroll Medicare retirees into the Aetna MAP with the option to opt-out of Aetna MAP to enroll into HIP VIP, and the purported disproportionate result. Also absent from the pleadings are any statistics that reflect the number

of New York City Medicare-eligible retirees under age 65 and non-Medicare-eligible retirees under age 65. *See* Burgis, 2018 N.Y. Slip 33322(U), *8; *see also Churches United for Fair Hous., Inc. v. De Blasio*, 2018 N.Y. Slip Op 31826(U), *18 (Sup. Ct. N.Y. Cnty. 2018) ("A plaintiff who fails to allege facts at the pleading stage or produce statistical evidence demonstrating a causal connection cannot make out a prima face case of disparate impact.").

Assuming that the Petition could demonstrate that the City's decision fell more harshly on Medicare-eligible retirees under age 65, by its own admission, the Petition states that the City's issued its decision to offer a sole healthcare plan to all Medicare-eligible New York City retirees, in part, because of the cost-savings. *See* Pet. ¶¶ 146-47, 349. As such, Petitioners' disparate impact claim fails.

B. Disparate Treatment

The Petition also fails to plead a disparate treatment claim. To state an invidious disability discrimination claim under the SHRL and CHRL, Petitioners must allege that, (1) they are members of a protected class; (2) that they were qualified for the position; (3) they were subjected to an adverse employment action or different treatment than other employees (under CHRL) and (4) that the adverse or different treatment occurred under circumstances that gave rise to an inference of discrimination. *See Harrington v. City of N.Y.*, 70 N.Y.S.3d 177, 180 (1st Dep't 2018).

First and foremost, Petitioners fail to identity their respective disabilities as prescribed under the applicable statutes. *See Delta Air Lines v. N.Y. State Div. of Human Rights*, 652 N.Y.S. 2d 253, 258 (1st Dep't 1996). Instead, they assert that certain Petitioners identify as Medicare-eligible retirees under the age of 65 and thus, are considered disabled. *See* Pet. ¶ 103. Even liberally construing the phrase "disabled Retirees," as qualifying as Petitioners' protected

class, the Petition lacks any allegations suggesting that all Petitioners are aggrieved based on their protected class by the enrollment of Medicare retirees into the Aetna MAP with the option to op-out of Aetna MAP to enroll into HIP VIP. *See* Pet. ¶ 325. Only a select number of the fifteen annexed affidavits suggest that they are indeed Medicare-eligible New York City retirees under age 65. *See* NYSCEF Nos. 29, 31.

None of the alleged conduct gives rise to an inference of disability discrimination or suggests that the subset of Petitioners were treated less well because of their protected class. *See Matter of Local 621 v. N.Y. Dep't of Trans.*, 111 N.Y.S.3d 588, 590 (1st Dep't 2019). As stated above, the decision to discontinue Senior Care and other Medicare plans and enroll Medicare retirees into Aetna MAP with the option to opt-out of Aetna MAP to enroll into HIP VIP has no bearing on anyone's protected classes. Specifically, the Petition fails to allege the purported comparators' attempts at obtaining similar medical treatment to claim that the unidentified individuals are indeed similarly situated. *See Thior v. Jetblue Airways Corp, 2021 N.Y. Slip Op 31818[U]*, *20 (Sup. Ct, N.Y. Cnty. 2021). The Petition rests solely on Petitioners' personal beliefs and individual perceptions of discrimination, which is insufficient to make out a claim. *See Wiggins v. Mount Sinani Hosps. Grp., Inc.*, 2020 N.Y. Slip Op 34254(U), *24 (Sup. Ct. N.Y. Cnty. 2020); *Sims v. Trs. Of Columbia Univ. in the City of N.Y.*, 2017 N.Y. Slip Op 32331(U), *25 (Sup. Ct. N.Y. Cnty. 2017) ("[A] plaintiff's speculations, generalities, and gut feelings, however genuine, when they are not supported by specific facts, do not allow for an inference to be drawn.") (internal citations omitted).

Consequently, the Petition is devoid of any allegations to suggest that the City took any action to differentiate between New York City retirees that are considered disabled and those New York City retirees that are not disabled.

POINT VII

PETITIONERS FAIL TO STATE A CLAIM FOR UNJUST ENRICHMENT

Petitioners' eighth cause of action for unjust enrichment fails as a matter of law because (1) the claim is duplicative of Petitioners' other claims, and (2) Respondents have not been unjustly enriched by implementing Medicare Advantage. "The doctrine of unjust enrichment invokes an 'obligation imposed by equity to prevent injustice, in the absence of an actual agreement between the parties concerned.'" *Pappas v. Tzolis*, 20 N.Y.3d 228, 234 (2012) (quoting *IDT Corp. v. Morgan Stanley Dean Witter & Co.*, 12 N.Y.3d 132, 142 (2009)). "The essential inquiry in any action for unjust enrichment . . . is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered." *Mandarin Trading Ltd. v. Wildenstein*, 16 N.Y.3d 173, 182 (2011) (quotation omitted).

To establish a claim for unjust enrichment under New York law, Petitioners must show that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit the other party to retain what is sought to be recovered. *Id.*; *E.J. Brooks Co. v. Cambridge Sec. Seals*, 31 N.Y.3d 441, 455-456 (2018); *Corsello v. Verizon NY, Inc.,* 18 N.Y.3d 777, 790-791 (2012). In *Corsello v. Verizon NY, Inc.,* the Court of Appeals found that:

> [i]n a broad sense, this may be true in many cases, but unjust enrichment is not a catchall cause of action to be used when others fail. It is available only in unusual situations when, though the defendant has not breached a contract nor committed a recognized tort, circumstances create an equitable obligation running from the defendant to the plaintiff. Typical cases are those in which the defendant, though guilty of no wrongdoing, has received money to which he or she is not entitled.

Corsello, 18 N.Y.3d at 790 (citations omitted).

"An unjust enrichment claim is not available where it simply duplicates, or replaces, a conventional contract or tort claim." *Id*. (citing *Clark-Fitzpatrick, Inc*., 70 N.Y.2d 382 (1987)). A

cause of action for unjust enrichment also does not lie where Petitioners have an "adequate remedy at law." *Samiento v. World Yacht Inc.*, 10 N.Y.3d 70, 81 (2008); *Town of Wallkill v. Rosenstein*, 40 A.D.3d 972, 974 (2d Dept 2007) (dismissing an unjust enrichment claim where it was duplicative of a legal malpractice action since the claims arose out of the same facts and plaintiffs did not allege distinct and different damages); *Am. Mayflower Life Ins. Co. v. Moskowitz*, 17 A.D.3d 289, 293 (1st Dept 2005) (dismissing an unjust enrichment claim where it was duplicative of fraud and forgery claims); *Wimbledon Fin. Master Fund, Ltd. v. Weston Capital Mgt. LLC*, 160 A.D.3d 596, 598 (1st Dept 2018) (dismissing an unjust enrichment claim where it was duplicative of a fraud action and did not seek specific damages based on unjust enrichment).

Petitioners allege that "Respondents have been and will be unjustly enriched by their decision to eliminate the option of Medicare supplemental insurance and replace it with only Medicare Advantage" (Pet. ¶ 344) because "they will have shifted the entire cost of health insurance onto Retirees"(Pet. ¶ 347). First, this claim is duplicative of Petitioners' other claims in the action as it arises out of the same facts and does not seek specific damages arising out of the unjust enrichment claim. Petitioners themselves allege in the unjust enrichment cause of action that "Respondents are statutorily and contractually required to continue offering and paying for, a choice of Medicare Supplemental Plans." *Id*. ¶ 352. Plainly, Petitioners have legal remedies other than unjust enrichment, and therefore this cause of action should be dismissed as duplicative.

Second, even if the claim were not duplicative, it would still fail as a matter of law because Petitioners cannot show the elements of unjust enrichment. Respondents are not being enriched at the expense of Petitioners and, in fact, cost savings would be directed to the stabilization fund, a fund jointly controlled by the City and MLC that provides significant assistance to both the City and the MLC unions and their benefit plans covering both active and retired members. *See* Opinion

and Award from Arbitrator Martin F. Scheinman regarding City of New York v. Municipal Labor Committee, dated June 24, 2021 ("Scheinman Decision"), which is annexed as part of Exhibit A to the Klinger Aff., at p. 175, NYSECF No. 80. The Stabilization Fund was established in June 1985, and its express purpose is to receive dividends, if any, from the GHI-CBP Plan, to provide a sufficient reserve for health benefits; to maintain to the extent possible the level of health insurance benefits provided under the Blue Cross/GHI-CBP plan; and, if sufficient funds are available, to fund new benefits. *Id*. The City and MLC also use the Stabilization Fund to pay for City budget needs, welfare fund contributions, prescription drug costs, and administrative costs associated with benefit cost savings programs. *Id*. at p. 176. The Stabilization Fund is critical for workers, retirees, and the City. *Id.* Any savings resulting from the implementation of the Medicare Advantage program would be directed to the Stabilization Fund. *See* Health Savings Agreements, which are annexed as **Ex. 1** to Ans. To the extent the savings benefit the City as a participant in the Stabilization Fund, in addition to other beneficiaries, any such benefit is not against equity nor is such collateral benefit unjust.

Finally, as discussed in Point V, *supra*, Medicare Advantage adheres to the City's responsibilities under NYC Admin. Code § 12-126 to pay for City Retirees' health insurance. The Respondents' actions in implementing Medicare Advantage are in compliance with all other applicable laws and regulations. Thus, Petitioners cannot maintain an action for unjust enrichment because Respondents have not been unjustly enriched at the expense of Petitioners.

POINT VIII

RESPONDENTS DID NOT VIOLATE CAPA IN IMPLEMENTING A NEW HEALTH CARE PLAN

Petitioners' ninth cause of action, alleging that Respondents violated the New York City Administrative Procedure Act ("CAPA") because they did not adhere to its rulemaking

requirements, also fails as a matter of law because Respondents' determination to change City Retirees' health care plans is a matter of internal agency management and not a rule subject to such requirements. Petitioners incorrectly assert that this change meets CAPA's definition of a rule (Pet. ¶ 368) and that implementing the new health care plan for City Retirees required Respondents to adhere to CAPA's formal rulemaking procedure.

City Retirees are not the "public" at large and so an exception to rulemaking requirements under CAPA applies here: § 1041(5)(b)(i) of CAPA excludes from the definition of a "rule" a "statement or communication which relates only to the internal management or personnel of an agency which does not materially affect the rights of or procedures available to the public." N.Y.C. Charter § 1041(5)(b)(i); *see Matter of Karl v. NY City Dept. of Citywide Admin. Servs.*, 21 Misc. 3d 1131[A], (N.Y. Sup. Ct., N.Y. Cnty. Sep. 24, 2008) (Agency directives "that are set to facilitate the internal management of the agency and do not materially affect the rights of the public in general" are exempt from rulemaking procedures).

The New York City Charter Revision Commission 1988 Report[13] (the "Charter Revision Report"), which was prepared almost contemporaneously by the staff that drafted this provision, is instructive on this matter. A copy of the Charter Revision Report is annexed hereto as **Ex. 7** to Ans. The Charter Revision Report provides in the introduction that it "presents a detailed, section-by-section analysis of the revisions to the New York City Charter approved by the voters in November 1988. The analysis describes the revisions, explains their meaning, and clarifies the Charter Revision Commission's intentions in proposing them." *Id.*, p. 1. With regard

[13] This Commission dissolved with the 1988 general election and the report was released shortly thereafter.

to the analysis with respect to the internal agency management/personnel exemption, the Charter Revision Report states:

> Paragraph b of subdivision 5 lists statements which are not to be considered rules. They are therefore exempted from CAPA's rulemaking procedures and from the Compilation requirement. These exclusions apply primarily to an agency's resource allocation, work force deployment, purely internal procedures and city employment-related matters, some of which are also often subject to collectively bargained provisions and are covered by other detailed regulations, legislation and judicial decisions. While these exceptions are not intended to provide an escape for agencies from their rulemaking responsibilities, they are intended to illustrate that certain agency acts are not, in essence, rules and do not require the same safeguards for their effectuation.

Id., p. 86-87.

The Federal Administrative Procedure Act contains a similar internal agency/personnel exemption. 5 USCS § 553, entitled *Rule making*, provides in subsection (b) (A) that the rule making procedures do not apply "to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." In *Tunik v. MSPB,* 407 F.3.d 1326, (Fed. Cir. 2005), the United States Court of Appeals for the Federal Circuit gave weight to the Attorney General's interpretation of the provision, which stated that the exemption applied to "any matter relating solely to the internal management of an agency" and that "[i]f a matter is solely the concern of the agency proper, and therefore does not affect the members of the public to any extent, there is no requirement for publication...Thus, an agency's internal personnel and budget procedures need not be published…" *Tunik* at 1342; *see also Conyers v. Secretary of VA,* 750 F App'x 993, 996-997 (Fed. Cir. 2018) ("The personnel exception disposes of the requirements set forth in 5 U.S.C. § 553(b)-(d), including notice-and-comment, for 'matter[s] relating to agency management or personnel.' 5 U.S.C. § 553(a)(2). Such matters may include determinations of employee

bonuses, the promulgation of a personnel manual or handbook, and hiring practices.") (quotation and citation omitted).

The New York State Administrative Procedure Act ("SAPA") also contains such an exemption. Section 102 of SAPA, entitled *Definitions*, provides in subdivision (2)(b)(i) that "rules concerning the internal management of the agency which do not directly and significantly affect the rights of or procedures or practices available to the public" are exempt. An agency determination that "relates to the organization or internal management of the agency" is exempt from rulemaking requirements. *Dubendorf v. NY State Educ. Dept.*, 97 Misc. 2d. 382, 394 (N.Y. Sup. Ct., Monroe Cnty. December 14, 1978) (quotation omitted) (finding a State agency's own internal auditing procedures and instructions are exempt). Although SAPA does not refer explicitly to "personnel" in its exemptions as CAPA does, it does contain a separate exemption in subdivision 2(b)(v) for rules implementing collective bargaining agreements. Further, "[t]he definition of a rule under CAPA is consistent with the definition a rule under the State Administrative Procedure Act. Consequently, legal authority interpreting SAPA is persuasive and may be relied upon in this court's inquiry." *Callahan v. Carey,* 2012 NY Slip Op 30400[U], *7 (N.Y. Sup. Ct., N.Y. Cnty. Feb. 22, 2012).

Here, a change in health care plans for City Retirees is exempt under CAPA because it is a matter of internal agency management and does not affect the general public. The new health care plans for City Retirees affects only retired City employees, rather than "the rights of or procedures available to the public." City Retirees' rights, as well as their dependents' rights, to City sponsored health care are derivative from governmental employment; essentially, their rights derive from City personnel procedures, which are adopted without rulemaking in the City's capacity as an employer. Such changes in health care plans do not affect "the rights of or

procedures available to the public" in the manner of, for example, business licensing rules of the Department of Consumer and Worker Protection that are promulgated under the police power of the City. Thus, the implementation of Medicare Advantage as health care for City Retirees falls under the exemption to the CAPA definition of "rule."

The New York State cases that Petitioners cite for their position that this change in City health care plans for City Retirees constitutes a rule under CAPA are inapplicable because none of those cases involved matters solely related to internal agency management and/or government personnel. For example, *Schwartfigure v. Hartnett*, 83 N.Y.2d 296 (1994), concerned the New York State Department of Labor in its role as a rulemaking body—not, as the City is here, in its role as employer with concomitant collective bargaining obligations.

Petitioners cite *Risedelaware Inc. v. Dematteis*, 2022 Del. Super. LEXIS 1028 (Super Ct. Oct. 19, 2022, No. N22C-09-526 CLS) for the proposition that the switch from Medicare plus supplemental insurance to Medicare Advantage is a rule under CAPA because a Delaware Court considered it a rule under Delaware law. However, this case is unavailing because Delaware's analogous Administrative Procedure Act does not contain an exemption for internal agency management/personnel matters. The definition of a rule (denominated Regulation) under the Delaware Administrative Act is:

> any statement of law, procedure, policy, right, requirement or prohibition formulated and promulgated by an agency as a rule or standard, or as a guide for the decision of cases thereafter by it or by any other agency, authority or court. Such statements do not include locally operative highway signs or markers, or an agency's explanation of or reasons for its decision of a case, advisory ruling or opinion given upon a hypothetical or other stated fact situation or terms of an injunctive order or license.

Del. Code Ann. tit. 29, § 10102.

The Delaware definition of Regulation does not provide for any exceptions, and thus a change in health care plans for Delaware retirees constituted a regulation under Delaware law. However, CAPA's definition of a Rule plainly includes this exemption, and it is applicable here.

A contrary interpretation of CAPA would lack a limiting principle, and potentially overturn decades of City practice by requiring a detailed code of rules, together with required delays and public hearings, for minute alterations to every component of City health insurance benefits – this new requirement would be in addition to existing collective bargaining relations and insurance law requirements. There is no evidence that the enactment of CAPA, at a time when the City already had a system of employee health benefits under section 12-126 of the Administrative Code, was intended to create such disruption.

In short, a change in health care plans is internal agency management that does not affect the "public" at large and, therefore, is not subject to the rulemaking procedures. Thus, Petitioners cannot maintain a claim that Respondents violated CAPA.

POINT IX

PETITIONERS FAIL TO STATE A CLAIM FOR NEGLIGENT MISREPRESENTATION

Petitioners erroneously argue that the City has negligently misrepresented the Aetna MAP and made misleading and inaccurate statements about their medical providers and the process for opting out of the Aetna MAP. Respondents hereby adopt and incorporate the arguments set forth in Proposed Intervenor Aetna's Memorandum of Law in connection with Petitioners' tenth cause of action. *See* Aetna MOL at 17-18.

POINT X

RESPONDENTS DID NOT VIOLATE THE DONNELLY ACT

Respondents hereby adopt and incorporate the arguments set forth in Proposed Intervenor Aetna's Memorandum of Law in connection with Petitioners' eleventh cause of action. *See* Aetna MOL at 18-21.

POINT XI

RESPONDENTS DID NOT VIOLATE ARTICLE V, SECTION 7 OF THE NEW YORK CONSTITUTION

Petitioners claim that, by making changes to the Retirees' health insurance coverage, Defendants have violated article V, section 7 of the New York Constitution, which provides in relevant part that "membership in any pension or retirement system of the state or of a civil division thereof shall be a contractual relationship, the benefits of which shall not be diminished or impaired." Pet. ¶ 392. However, it is has been long established by the Court of Appeals that "[h]ealth insurance benefits are not within the protection of article V, section 7 of the State Constitution." *Lippman v. Bd. of Educ.*, 66 N.Y.2d 313, 315 (1985); *see also D'Antonio v. Metro. Transp. Auth.*, No. 06 cv 4283(KMW), 2008 U.S. Dist. LEXIS 16726, at *14 (S.D.N.Y. Mar. 4, 2008) (in action arising from alleged wrongful diversion of money from plaintiffs' retirement health benefit funds, court held that plaintiffs failed to state Article 5, § 7 claim because "Article 5, § 7 does not apply to changes to retirement health benefits") (citing *id.*). Rather, article V, section 7 protects only "the financial benefits promised in the pension contract" itself. *McDermott v. McDermott*, 119 A.D.2d 370, 382 (2d Dep't 1986).

Petitioners allege that because N.Y.C. Admin. Code § 12-126 "expressly conditions" the Retirees' health insurance benefits "on membership in a City pension or retirement

system," those benefits are nevertheless a constitutionally protected "contractual benefit." Pet. ¶¶ 393-94. But this allegation does not distinguish this action from the controlling precedent. Indeed, in the Court of Appeals' *Lippman* decision, a state statute required the petitioners' disputed health insurance benefits to be paid for, in part, by deductions from the "retirement allowance[s]" that the *Lippman* petitioners received as members of a pension or retirement system. 66 N.Y.2d at 316, 319. Despite the fact that the health insurance benefits in *Lippman*, like the Retirees' health insurance coverage in this action, were statutorily linked to pension or retirement system benefits, the Court of Appeals held that health insurance benefits were not themselves constitutionally protected retirement benefits. *Id.* at 318-19.

Because the health insurance coverage at issue in this case is not protected by article V, section 7 of the New York Constitution, Petitioners' article V, section 7 claim should be denied.

POINT XII

PETITIONERS FAIL TO ESTABLISH THAT THEY ARE ENTITLED TO PRELIMINARY RELIEF

Petitioners' application for a preliminary injunction must be denied because Petitioners have failed to demonstrate that they are entitled to this extraordinary relief. The decision whether to grant injunctive relief is a matter of discretion for the trial court. *Doe v. Axelrod*, 73 N.Y.2d 748, 750 (1988). "'In the absence of a clear right to the relief demanded, injunctive relief should not be granted until the issues have been fully explored and the entire matter resolved after plenary trial.'" *Little India Stores, Inc. v. Singh*, 101 A.D.2d 727, 728 (1st Dep't 1984) (quoting *Gulf & Western Corp. v. New York Times Co.*, 81 A.D.2d 772, 773 (1st Dep't 1981)).

In order to obtain interim injunctive relief, the movant must demonstrate: "(1) the likelihood of ultimate success on the merits; (2) the prospect of irreparable injury if the injunction

is not issued; and (3) a balance of the equities in the movant's favor." *Housing Works, Inc. v. City of New York*, 255 A.D.2d 209, 213 (1st Dep't 1998). "Conclusory statements lacking factual evidentiary detail warrant denial of a motion seeking a preliminary injunction." *1234 Broadway LLC v. W. Side SRO Law Project*, 86 A.D.3d 18, 23 (1st Dep't 2011).

Petitioners fail to establish any, let alone all, of these elements.

A. Petitioners Cannot Demonstrate a Likelihood of Success on the Merits

To demonstrate the likelihood of success on the merits, Petitioners' right to such relief must be "certain as to the law and the facts and the burden of establishing such an undisputed right rests upon the [movant]." *Buegler v. Walsh*, 111 A.D.2d 206, 207 (2d Dep't), *appeal dismissed*, 65 N.Y.2d 1012 (1985) (quoting *Camardo v Board of Educ.*, 50 A.D.2d 1073). *See Doe*, 73 N.Y.2d at 750 (reversing grant of preliminary injunction where plaintiffs failed to demonstrate likelihood of success on the merits); *Chester Civic Improvement Ass'n v. New York City Transit Auth.*, 122 A.D.2d 715, 717 (1st Dep't 1986) (affirming denial of preliminary injunction even where plaintiff arguably established irreparable injury because plaintiff failed to establish a clear likelihood of success on the merits).

As more fully set forth above, Petitioners have not established a likelihood of success on the merits because, inter alia, the City's plan to implement the Aetna MAP is lawful and reasonable, and each of Petitioners' various challenges to the plan must be rejected. *See* Points I-XI, supra.

B. Petitioners Cannot Demonstrate that they Will Suffer Irreparable Injury

Petitioners' claims of irreparable harm fail for the same reasons as their substantive claims. While Petitioners go to great lengths to paint the Aetna MAP as an inferior health insurance plan that will fail to provide them with adequate coverage, these allegations are not borne out by the facts. As more fully set forth above, the Aetna MAP is a comprehensive, high-quality insurance

plan that was designed specifically for New York City retirees and selected through a rigorous procurement process. In short, Petitioners will not suffer irreparable harm absent a preliminary injunction because they will continue to receive premium-free, comprehensive health care coverage that they currently enjoy.

C. The Balance of Equities Tips in Favor of Respondents

Petitioners cannot demonstrate that the equities tip in their favor because any further delay in the implementation of the Aetna MAP will derail it. The City must adhere to a strict timeline in order to be able to implement the new contract as planned on September 1, 2023. The opt-out deadline, which was set to end on June 30, 2023, but which the City now agreed to extend, in light of this litigation, until July 10, 2023, is only the first of several steps in this process. Under the already-constricted timeline now in place, Aetna will have less than one week-until July 13, 2023, to send the opt-out file and enrollment confirmation to the City. The City's Financial Information Services Agency ("FISA") will then have five days (three business days)—from July 14 to July 18—to process the opt-out file; and the City, together with Aetna, will have six days (four business days)—from July 19 to July 24—to reconcile the conversion file, and less than two days—from July 24 to July 25—to prepare and send the final conversion file. Aetna will then have just ten days to submit the enrollment file to the Centers for Medicare & Medicaid Services ("CMS"), the federal agency within the United States Department of Health and Human Services that administers the Medicare program, by August 4, 2023. Following this submission, Aetna would have an additional three days (from August 7 to August 10) to reconcile any enrollment data that was rejected by CMS, before Aetna could issue insurance ID cards to retirees on August 15, 2023, to ensure retirees receive them by the September 1, 2023, effective date. Ans. ¶ 448, n.5.

Any delay in this transition process will mean that the new retiree coverage could not be in place by September 1, 2023—again derailing the City's multi-year effort to implement

necessary cost-savings while maintaining comprehensive, high-quality health insurance coverage for retirees. *Id.* While Petitioners continue to portray the City's efforts to achieve cost-savings as part of some nefarious project, the reality is that the more than $500 million in savings that will be realized through implementation of MAP will be allocated to further stabilization of health benefit plans for the benefit of both retirees and active employees. Ans. ¶ 413.

Petitioners' glib assertion that another preliminary injunction will not harm the City because it will merely "maintain a status quo," and the unsupported assumption that "the City can easily wait for a decision on the merits before implementing its new healthcare policy" (Br. at 67) ignore the realities of City budgets and procurement processes. Contrary to Petitioners' contention (*id.* at 68), the fact that the City has a contingency plan in place for the unlikely issuance of a further injunction does not immunize the City (or the retirees not represented in this litigation) from the harms that would be caused by further delay. Just as in the case of "the Retirees' previous two lawsuits" (*id.*), any delay puts the City's short-term and long-term priorities and obligations in jeopardy.

In addition to derailing the City's plan, such a delay would cause further confusion for retirees who have been subject to a near-constant stream of changing information over the past two years. While Petitioners purport to speak for all retirees, they actually consist of just one nonprofit organization and eight individual retirees, and the many retirees who do not object to the Aetna MAP and would prefer to have this issue put to rest will suffer the confusion and uncertainty caused by further delay.

To impose such a result before the Court has fully considered the complete record would be unjust to the City and the retirees. *See Gulf & Western Corp. v. New York Times Co.*, 81 A.D.2d 772, 773 (1st Dep't 1981) (reversing decision granting preliminary injunction where

plaintiffs failed to demonstrate that "'the balance of convenience and relative hardship -- the harm to plaintiff from denial of the injunction as against the harm to defendant from granting it' tips in plaintiff's favor") (quoting *Edgeworth Food Corp. v Stephenson*, 53 A.D.2d 588 (1st Dep't 1976)).

CONCLUSION

For the foregoing reasons, the Petition should be denied and dismissed in its entirety and Petitioners' motion seeking a preliminary injunction should be denied.

Dated: New York, New York
June 16, 2023

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SECTION 202.8-B CERTIFICATION

I certify that the total word count of this Memorandum of Law is 19,365, which complies with Section 202.8-b of the Uniform Civil Rules For The Supreme Court & The County Court. I relied on the word count of the word-processing system used to prepare the document.

Dated: New York, New York
June 16, 2023

/s/ Michelle Lee
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