FILED: APPELLATE DIVISION - 1ST DEPT 03/29/2023 11:17 AM
NYSCEF DOC. NO. 14
2023-00232
RECEIVED NYSCEF: 03/29/2023

To Be Argued By:
Jacob S. Gardener
Time Requested: 15 Minutes

New York County Clerk's Index No. 160234/2022

New York Supreme Court

APPELLATE DIVISION — FIRST DEPARTMENT

Case No. 2023-00232

MARGARETANN BIANCULLI, JANET KOBREN, MERRI LASKY, PHYLLIS LIPMAN, BARRY SKOLNICK, on behalf of themselves and all others similarly situated, and the NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC.,

Plaintiffs-Respondents,

against

THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS, THE CITY OF NEW YORK, EMBLEMHEALTH, INC., and GROUP HEALTH INCORPORATED (GHI),

Defendants-Appellants.

BRIEF FOR PLAINTIFFS-RESPONDENTS

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QUESTION PRESENTED

This appeal presents the following question:

Did Supreme Court abuse its discretion by preliminarily enjoining an insurance company from imposing contractually forbidden co-pays on elderly and disabled retired City workers who were forced to forego medical care and other necessities as a result of the co-pays?

Answer: No.

Plaintiffs-Respondents Margaretann Bianculli, Janet Kobren, Merri Lasky, Phyllis Lipman, Barry Skolnick, on behalf of themselves and all others similarly situated, and the NYC Organization of Public Service Retirees, Inc. respectfully submit this memorandum of law in opposition to the appeal of Defendants-Appellants the New York City Office of Labor Relations ("OLR"), the City of New York (together with OLR, "the City"), EmblemHealth, Inc., and Group Health Incorporated ("GHI," and, together with EmblemHealth, Inc., "Emblem") from a Decision and Order entered in the Supreme Court, New York County on January 11, 2023 granting Plaintiffs' preliminary injunction motion.

PRELIMINARY STATEMENT

Medicare-eligible (*i.e.*, elderly and/or disabled) retired municipal workers spent their careers serving—and, in many cases, risking their lives for—this City. These former teachers, paramedics, crossing guards, and other civil servants now survive on fixed pensions, tens of thousands of which are less than $1,500 a month. Given their financial constraints and frequent medical needs, few can afford to enroll in a healthcare plan that charges co-pays for medical services.

Unsurprisingly, the overwhelming majority of Medicare-eligible retired City workers and their Medicare-eligible spouses have, for decades, enrolled in a healthcare plan known as "Senior Care." Prior to 2022, Senior Care never charged co-pays for medical services. That is because it is forbidden. The contract between the City and Emblem, the insurance company that administers the medical services component of Senior Care, promises Senior Care enrollees ("Retirees") that "Medicare will pay 80% of the reasonable charge of your covered service" and "[Emblem] will pay the 20% balance." (R160, 221.) Co-pays violate that contractual promise by shifting a portion of the 20% balance onto Retirees.

In January 2022, with less than two weeks' notice, Emblem suddenly began charging Retirees a $15 co-pay every time they visited the doctor or received a medical test, procedure, treatment, or therapy. Not only did Emblem violate Retirees' contractual rights by charging these co-pays, it also violated Retirees' statutory and common law rights by falsely assuring them during the healthcare open enrollment period that there would be no such co-pays.

Plaintiffs brought this putative class action last year to vindicate these rights. And they simultaneously moved for a preliminary injunction to prohibit the continued imposition of these unlawful co-pays, which were causing irreparable harm.

Although $15 might not sound like much to some, when that unexpected expense is repeatedly forced on a senior citizen living on a small, fixed income, it becomes unbearable. As public records show, most Retirees subsist on meager pensions. And because they are all elderly and/or disabled, they either require or are at high risk of requiring regular medical care. As evidenced by numerous affidavits, public data, and common sense, countless Retirees were unable to afford the accumulating co-pays for such medical care and had to either forego care or cut back on other necessities such as medicine, food, housing, heat, and electricity. Such harm cannot be remedied after the fact through a damages award, which is why courts in New York and around the country have consistently held it to be irreparable. Defendants' callous attempt to characterize this suffering as purely monetary and undeserving of preliminary injunctive relief ignores both reality and controlling caselaw.

Because the co-pays violated Retirees' contractual and other rights and posed an undeniable threat of irreparable harm, Supreme Court did not abuse its discretion by preliminarily enjoining them. Accordingly, this Court should affirm.

NATURE OF THE ACTION

A. Background

This case involves a putative class of approximately 183,000 Medicare-eligible (*i.e.*, elderly and/or disabled) retired New York City workers and their spouses who are enrolled in the federal Medicare program as well as a "Medigap" plan known as Senior Care. Like other Medigap plans, Senior Care insures the portion of healthcare expenses that Medicare does not cover.

Senior Care covers two types of services: (1) medical services, which include virtually all medical care such as doctor's visits, surgery, chemotherapy, laboratory tests, physical therapy, in-home nursing care, etc.; and (2) hospital services. Emblem administers the medical services component pursuant to a contract (the "Contract") between it and the City. (R72-270, 357.) Empire BlueCross BlueShield ("Empire") administers the hospital services component pursuant to an entirely

separate contract with the City. (R39, 357.) This case concerns only the medical services provided by Emblem pursuant to its Contract, which does not allow co-pays for such services. Empire is not a defendant, and the hospital services it provides under its contract with the City—which *does* allow co-pays—are not at issue.

For decades, the vast majority of Medicare-eligible retired City workers have enrolled in Senior Care. That is partly due to its ease of use: Retirees can go to virtually any doctor they wish (unlike competing plans with limited networks), and can receive any test, procedure, treatment, or therapy ordered by their doctor without first having to obtain approval from the insurance company (a process known as "prior authorization"). Senior Care's popularity is also due to its attractive cost structure: pursuant to N.Y.C. Administrative Code § 12-126, Retirees cannot be charged monthly premiums (the City must cover this cost); and, pursuant to the Contract, they cannot be charged co-pays for medical services.[1] (R23, 47.)

[1] In 2021, the City tried to make Retirees pay the $191 monthly Senior Care premium in order to force them into a federally funded—and far inferior—type of healthcare plan called "Medicare Advantage." Supreme Court enjoined that unlawful maneuver, and this Court unanimously affirmed. *See NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 2022 WL 624606, at *2 (Sup. Ct. N.Y. Cty. Mar. 3, 2022), *aff'd*, 2022 WL 17096611 (1st Dep't Nov. 22, 2022).

In January 2022, for the first time in history, Emblem suddenly began charging Retirees co-pays for medical services. Neither Emblem nor the City notified Retirees of this drastic change to their healthcare benefits until just a few days before it took effect.[2] Retirees were caught off guard, and they could not escape. Due to the City's open enrollment rules, in which Retirees could only switch healthcare plans during the fall of even-numbered years, Retirees who had enrolled in Senior Care in the fall of 2020 remained in the plan through the end of 2022. (R394.) When Retirees finally had an opportunity to transfer to a different plan during the open enrollment period in November 2022, many had no choice but to stay in Senior Care, despite the co-pays, in order to continue seeing their doctors and to avoid the dangerous prior authorization requirements imposed by other plans. Regardless, as explained further below, they were led to believe by Emblem that there would be no co-pays for medical services going forward.

The co-pays had a devastating impact on the health and well-being of Retirees. Healthcare visits often involve multiple services (*e.g.*, an

[2] The first time Retirees were notified of the co-pays was in a letter mailed by Emblem on December 17, 2021, which arrived days later during the week of Christmas. (R786-87.)

examination by a physician, a lab test, and review of that test by a specialist), and thus multiple co-pays. Many of these senior citizens and disabled first responders—particularly those with chronic conditions that require regular medical attention—quickly began incurring hundreds, and even thousands, of dollars in co-pays. (R27-30, 49, 704-11, 721-42.) Because they live on limited, fixed incomes—often less than $1,500 a month—and had no opportunity or reason to budget for this unexpected expense, countless Retirees started drowning in co-pays they could not afford. (*Id.*) As a result, they were eventually forced to either forego needed medical care or reduce spending on other necessities such as medicine, food, housing, heat, electricity, and transportation. (*Id.*)

The co-pays were not just devastating and unprecedented, they were also unlawful. As discussed below, they violated Retirees' rights under the Senior Care Contract, which prohibits co-pays for medical services. And Emblem's false and misleading representations in the fall of 2020 and 2022 that there would be no Senior Care co-pays for medical services misled Retirees and violated their statutory and common law rights.

B. The Contract

As noted above, the medical component of the Senior Care plan is governed by a contract (the "Contract") between the City and Emblem. In that Contract, signed on February 25, 2000, the City agreed to pay Emblem to provide health insurance benefits to active and retired City employees and their dependents, all of whom are referred to in the Contract as "Members." (R72, 75.) The Contract was set to remain in effect "for the duration of the first Contract Period [(July 1, 1997 through June 30, 2002)] and thereafter, unless this Contract is terminated as provided herein." (R.75.) The Contract has not been terminated and therefore remains in effect today.

The Contract describes the benefits that Emblem must provide to City employees, retirees, and their dependents (the "Members") who enroll in one of the Emblem plans. The Contract states that "[e]ach Member shall be entitled to the medical benefits described in the Certificate(s) of Insurance and any riders or agreements made thereto attached hereto and made a part hereof." (R80.)

The Emblem Certificate of Insurance and all applicable riders thereto (together the "COI") are packaged together in a single document

and published online by Emblem. (*See* R112-270.) The COI is 159 pages and explains the different sets of benefits provided to: (1) City employees and non-Medicare-eligible retirees enrolled in Emblem's Comprehensive Benefits Plan ("CBP"); and (2) Medicare-eligible Retirees enrolled in Emblem's Senior Care plan. To be clear, CBP and Senior Care are two separate plans, with different terms, serving two mutually exclusive groups of Members (employees and non-Medicare-eligible retirees are in CBP; Medicare-eligible Retirees are in Senior Care). The two plans both happen to be addressed in the same certificate of insurance because they are both administered by Emblem.

Employees and non-Medicare-eligible retirees—unlike Medicare-eligible Retirees—do not receive any healthcare benefits through Medicare. Accordingly, CBP provides them with comprehensive health insurance coverage. The terms and costs of such coverage are very different from Senior Care, which, unlike CBP, merely fills in the gaps of Medicare. One such difference between CBP and Senior Care has always been co-pays. As the COI explains, many of the services covered under CBP require co-pays. (*See* R132-33, 139, 145, 217, 254 (listing the co-pays for CBP-covered services).) These co-pay amounts have increased

over time, as reflected in COI riders. (*See, e.g.*, R217, 254 (2004 rider showing the co-pay increase that became effective that year for employees and non-Medicare-eligible retirees enrolled in CBP).)

The benefits provided to Medicare-eligible Retirees under Senior Care are addressed in a separate section of the COI, specifically Section Fourteen. (*See* R160-61 (Section Fourteen), 220-21 (2004 rider amending Section Fourteen).) As the COI explains, when Retirees turn 65, they "become eligible for Medicare," and if they enroll in Senior Care, they "receive only those benefits listed in this Section Fourteen." *Id.* Section Fourteen lists the various medical services that are covered under Senior Care. (R160-61, 221.) None of them requires co-pays. *Id.*[3] That is because such co-pays are contractually prohibited.

Under the Contract, after a small annual deductible is met, "Medicare will pay 80% of the reasonable charge of your covered service" and "[Emblem] will pay the 20% balance." (R160, 221.) Thus, if, for example, the Medicare fee schedule lists the reasonable charge for a

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[3] Prescription drugs, which are outside the realm of traditional Medicare (R39), are not a service covered under Senior Care. However, Emblem offers Retirees the option to enroll in and pay for such coverage separately. (R161-63, 223.) As the Contract makes clear, this optional prescription drug coverage, unlike the services covered under Senior Care, requires co-pays. *Id.*

particular service as $100, Medicare will pay $80 and Emblem is contractually obligated to pay the remaining $20. A co-pay violates this contractual arrangement. By imposing a $15 co-pay on the service, the Retiree pays $15 and Emblem pays only $5 (not $20).[4]

In sum, the COI—which is incorporated by reference into the Contract—has long allowed co-pays for CBP but has never allowed them for Senior Care. For decades (up until 2022), that reflected reality: CBP imposed co-pays, while Senior Care did not. In 2022, Retirees who were enrolled in Senior Care were suddenly—for the first time ever—charged co-pays every time they saw a doctor or received a medical test, procedure, treatment, or therapy. However, the COI does not allow that. Because the COI sets forth the contractual obligations of the City and Emblem with respect to Senior Care benefits for Retirees, the imposition of co-pays constitutes a clear breach of the Contract.

[4] This is not to say that a Retiree never has to pay anything under the Contract. If the Retiree chooses to go to one of the few doctors that does not follow the Medicare fee schedule, she will have to pay the difference between whatever that doctor charges for a given service and the Medicare-approved rate for that service. (R160.) In addition, there are instances where, by operation of law, Medicare may reduce its payment below 80% of the Medicare-approved rate. (*Id.*) Under either scenario, however, Emblem is still contractually obligated to pay the full 20% of the Medicare-approved rate and cannot pass along any of that cost to the Retiree through co-pays.

C. Emblem's Deceptive Conduct

Emblem not only imposed co-pays on Retirees in breach of the Contract, it did so deceptively. As explained below: (1) Emblem implemented the co-pays in January 2022 after falsely assuring Retirees during the previous open enrollment period there would be no such co-pays; and (2) when Retirees finally had an opportunity to switch plans during the fall 2022 open enrollment period, Emblem once again falsely represented that, going forward, there would be no co-pays for medical services. These false promises of no co-pays were designed to, and did, induce Retirees to remain enrolled in Senior Care, thereby ensuring that Emblem would continue to earn hundreds of millions of dollars in annual premiums.

Because Supreme Court granted Plaintiffs' preliminary injunction motion based on the breach of contract, it did not have occasion to address this additional misconduct, which provides a separate and independent basis for the injunction. Although this Court can likewise affirm without addressing Emblem's deceptive conduct, we briefly summarize it here for the Court's benefit.

In order to appreciate Emblem's deception, some context regarding Retirees' health insurance selection process is required.

All active and retired City workers and their dependents are given a choice of health insurance plans, which are made available through the NYC Health Benefits Program. Every fall, there is an open enrollment period during which individuals can select their health insurance plan for the upcoming calendar year. Up until this year, Retirees (unlike active employees) could only switch plans during the open enrollment period in even-numbered years. (R394.)[5] This means that, because 2021 was an odd-numbered year, Retirees could not transfer in or out of Senior Care during the fall 2021 open enrollment period. They were committed to whatever enrollment decision they made in the fall of 2020 for two years (2021 and 2022). Retirees were able to participate in the fall 2022 open enrollment period, which occurred in November, thus allowing them to choose whatever plan they wanted for 2023.

[5] Retirees can also switch plans once anytime during their life. *Id*. However, this option is a one-time emergency lifeline meant to protect against a sudden and unexpected change in a Retirees' personal circumstances. It was not meant to be squandered responding to Emblem's unlawful imposition of co-pays.

In order to allow individuals to make an informed healthcare enrollment decision, the City publishes in October—as part of the open enrollment process—a comprehensive booklet called the Summary Program Description ("SPD"). The SPD is 84 pages long and contains key information about all of the health insurance plans available to employees, retirees, and their dependents. (R289-372, 376-459.) It is designed to provide employees and retirees an accurate summary of the healthcare benefits and financial costs (including co-pays) associated with every plan, thus allowing individuals to competently evaluate and compare their healthcare options and select the one that best serves their needs. (R44.) Although the City publishes the SPD, the insurance companies provide the relevant summaries of their plans. (R46.)[6]

Throughout their decades-long careers and retirements, Retirees were instructed by Defendants to rely on the SPDs when making their healthcare enrollment decisions.[7] Retirees were further advised to make

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[6] *See also In the Matter of Group Health Insurance*, Assurance of Discontinuance No. 14-181, https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-09-8_GHI_CBP_OON-Fully_Executed_AOD.pdf ("AOD No. 14-181") at ¶ 6 ("[Emblem] prepared the section describing [its] Plan for NYC's use in the Summary Program Description.").

[7] For instance, Retirees were told by the City: "Review this [SPD] as carefully as possible. You will find that it is a valuable resource, both in making the initial selection, and as a comprehensive guide to understanding your health benefits before

their enrollment decisions based on the information in the SPDs, without needing to review more in-depth information.[8] One of the most important factors Retirees were told "you should consider" was "cost," including whether the "plans require copayments."[9] Retirees with limited resources who require frequent medical attention understandably seek an insurance plan with no co-pays.

The October 2020 SPD, on which Retirees relied when choosing their healthcare plan for 2021 and 2022, did not mention that Senior Care would, or even might, have co-pays for medical services. (R444.) To the contrary, it assured Retirees that there would be no such co-pays. (*Id.* (stating that Emblem would pay the full "20% of Medicare Allowed Charges" that Medicare did not cover).) Thus, when Senior Care co-pays

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you need to use them." https://www.osaunion.org/online/nov04/2004Health Benefits.pdf, at PDF p.2. Retirees were also advised: "This Summary Program Description provides you with a summary of your benefits under the New York City Health Benefits Program. Health insurance and the health care system can be complicated and confusing. This booklet was developed to help you to understand your benefits . . . ." https://www.ccny.cuny.edu/sites/default/files/hr/upload/NYC-Health-Insurance-Summary-Program-Decription.pdf, at 1.

[8] *See, e.g., id.* (stating that "[t]he plan you have chosen will send you an in-depth description of its benefits when you enroll"); R316 ("The plan you have chosen will send you information regarding your health benefits coverage when you enroll."); R403 (same).

[9] *Id.*

were suddenly imposed in 2022, Retirees were caught unaware and with no practical escape.

The October 2022 SPD, on which Retirees relied when making their enrollment decision this past November, similarly deceived Retirees. Like the October 2020 SPD, it did not mention any co-pays for Senior Care medical services, and it assured Retirees that Emblem would pay the full "20% of Medicare Allowed Charges" going forward. (R357.) Emblem violated this promise when it continued to impose co-pays in 2023, up until the preliminary injunction took effect on January 12.

Sadly, Emblem has a long history of deceiving Retirees and others in its SPD materials. For example, in 2014, an investigation by the New York Attorney General revealed that Emblem was withholding and misrepresenting critical information about the costs associated with its health insurance.[10] Such misconduct was found to have prevented "NYC employees and retirees [from] mak[ing] well-informed decisions in selecting the appropriate health plan."[11] As a result, Emblem was forced to take significant corrective measures and pay millions of dollars to

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[10] *See* AOD No. 14-181.

[11] *Id.* at ¶ 17.

compensate its victims.[12] Other investigations have revealed similar misconduct—including the improper charging of co-pays—for which Emblem has had to pay tens of millions of dollars in restitution and fines.[13]

Emblem's deception with respect to co-pays for Senior Care stands in contrast to the accurate information provided by other insurance companies. Indeed, other insurers complied with their obligation to provide in the SPDs truthful information about the co-pays (if any) applicable to their plans. (*See* R407-56, 320-80.)

Emblem touts the fact that it provided notice of the Senior Care co-pays in a unique version of the SPD that was briefly posted on a City website in December 2021. Emblem's Br. at 7. That version stated that

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[12] *Id.* at ¶¶ 27-37.

[13] *See, e.g.*, *In the Matter of EmblemHealth, Inc.*, Assurance of Discontinuance No. 14-031, https://ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf (explaining Emblem's wrongful denial of healthcare benefits, including improper imposition of co-pays, resulting in potential restitution of more than $31 million and $1.2 million penalty); *In the Matter of Group Health Insurance*, Assurance of Discontinuance No. 12-023, https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/AOD_GHI.pdf (explaining Emblem's misleading representations regarding insurance costs and requiring restitution to victims); *NY Attorney General Settlement Announcement* (December 18, 2018), https://ag.ny.gov/press-release/2018/ag-underwood-announces-settlement-emblemhealth-ensure-health-insurance-coverage (summarizing Emblem's practice of improperly denying coverage and the restitution and penalties it agreed to pay). *See also Plavin v. Grp. Health Inc.*, 35 N.Y.3d 1, 8 (2020) (holding that plaintiffs had adequately alleged violations of General Business Law §§ 349 and 350 arising from Emblem's misleading SPD materials).

"PCP and Specialist services are subject to a $15 copay." (R528.)[14] However, this brief disclosure was meaningless. Retirees had no reason to go online and review the SPD in 2021, much less in December 2021. They could not participate in open enrollment that year because it was an odd-numbered year. And even if they could participate (which they could not), the open enrollment period does not extend through December. Thus, the only thing that the December 2021 version of the SPD accomplished was to show what the 2020 and 2022 SPDs should have said, but did not.

Emblem's deception was not limited to the SPDs. It also extended to the health insurance ID cards sent to Retirees. Emblem sends all of its CBP and Senior Care Members a health insurance card that lists their name and basic information about their medical benefits. The cards provided to those enrolled in CBP (who are all active employees or non-Medicare-eligible retirees) disclose the co-pays applicable to that plan.

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[14] This version, however, was immediately taken down. In January 2022 and continuing thereafter through the fall 2022 open enrollment period, the SPD again made no mention of the $15 co-pays and misrepresented that Emblem would pay the full "20% of Medicare Allowed Charges." (R357, 613.).

(R631.) By contrast, the cards sent to Retirees enrolled in Senior Care do not mention any co-pays. (R629-30.)

D. Procedural History

Since 2021, Plaintiff NYC Organization of Public Service Retirees and the elderly and disabled retired City workers who comprise its membership have been engaged in non-stop litigation and political action to prevent the City from defunding their health insurance. These efforts have thus far been successful. In fact, just a few months ago, this Court unanimously held that the City's attempt to charge Retirees thousands of dollars a year for Senior Care was unlawful. *See NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 210 A.D.3d 559, 559 (1st Dep't 2022). Unfortunately, every legal and political victory the Organization has achieved has only prompted the City to take more extreme measures, culminating in its most recent decision to stop offering Senior Care or any other Medigap plan altogether starting on September 1, 2023.[15] If that unprecedented policy takes effect, it will have catastrophic consequences (including disruption of care) for countless senior citizens.

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[15] *See* Letter from OLR Commissioner Renee Campion (March 10, 2023), https://www.nyc.gov/assets/olr/downloads/pdf/health/aetna-ma-docs/ma-letter-retiree--letter-final-3-10-23.pdf.

Because the Retirees have very limited resources, which were spent combatting these existential threats to their healthcare, they had to delay filing the present co-pay suit. However, after enduring months of unlawful co-pays that were depleting their bank accounts, many Retirees could no longer await relief.

Accordingly, in November 2022, Plaintiffs filed this putative class action and simultaneously moved for a preliminary injunction to prevent Defendants from imposing any further co-pays on medical services. (R21-71, 675, 715.)

On January 11, 2023, Supreme Court granted Plaintiffs' motion and preliminarily enjoined Defendants "from imposing co-payments for the GHI Senior Care plan pending determination of this action." (R12.) The court concluded that: (1) the injunction was prohibitory, rather than mandatory, and therefore not subject to a heightened standard; (2) Plaintiffs were "highly likely to succeed on the merits of this action" because the co-pays constituted a clear breach of the Contract; (3) because the co-pays were causing Plaintiffs and other Retirees to forego medical care and other necessities, there would be irreparable harm in the absence of an injunction; and (4) the balance of the equities

favored Plaintiffs since the hardship they faced outweighed the administrative burden on Emblem. (R7-12.)

Supreme Court ordered the injunction to take effect upon the posting of a bond (R12), which Plaintiffs did the following day on January 12. (NYSCEF No. 68.)

Defendants immediately complied with the preliminary injunction order. On January 12, 2023, Emblem stopped charging co-pays on Senior Care medical services.

ARGUMENT

A preliminary injunction should be granted where, as here, (1) plaintiffs have shown "a probability of success on the merits," (2) there is a "danger of irreparable injury in the absence of an injunction," and (3) the balance of equities tips in their favor. *Nobu Next Door, LLC v. Fine Arts Hous., Inc.*, 4 N.Y.3d 839, 840 (2005).

"The decision to grant or deny a preliminary injunction lies within the sound discretion of the trial court." *Gilliland v. Acquafredda Enterprises, LLC*, 92 A.D.3d 19, 24–25 (1st Dep't 2011). Accordingly, "this Court will not disturb a trial court's grant of a preliminary injunction absent an improvident exercise of discretion." *Id.*

Because there was no such abuse of discretion here, this Court should affirm the preliminary injunction order.

I. SUPREME COURT APPLIED THE CORRECT STANDARD TO THIS PROHIBITORY INJUNCTION.

Defendants misconstrue the standard applicable to the preliminary injunction. Although Defendants are correct that a heightened standard applies to "mandatory injunctions" where "the plaintiff would receive the ultimate relief sought," *St. Paul Fire & Marine Ins. Co. v. York Claims Serv., Inc.*, 308 A.D.2d 347, 349 (1st Dep't 2003), this is not such a case. *See also Second on Second Cafe, Inc. v. Hing Sing Trading, Inc.*, 66 A.D.3d 255, 273 (1st Dep't 2009) (noting the "heightened standard for the grant of a mandatory preliminary injunction"). As explained below, the preliminary injunction here is prohibitory, not mandatory, and does not award the Retirees the ultimate relief they seek. Therefore, they need not satisfy any heightened standard.[16]

A. The preliminary injunction is prohibitory.

As Emblem notes in its brief, a mandatory injunction "command[s] the performance of some affirmative act," whereas a prohibitory

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[16] The City did not argue below that a heightened standard should apply. (R796-818.) Therefore, it has waived this argument. *Feliz v. Fragosa*, 85 A.D.3d 417, 418 (1st Dep't 2011).

injunction "operates to restrain the commission or continuance of an act." Emblem's Br. at 16-17 (quoting *State v. Town of Haverstraw*, 219 A.D.2d 64, 65–66 (2d Dep't 1996)); *see also Second on Second Cafe*, 66 A.D.3d at 264 (explaining that mandatory injunctions, unlike prohibitory injunctions, compel performance of affirmative acts).

The preliminary injunction here is prohibitory, not mandatory. Indeed, Supreme Court did not "command[] the performance of some affirmative act." It "restrain[ed] the commission or continuance of an act." Specifically, it "preliminarily enjoined" Defendants "from imposing co-payments for the GHI Senior Health Care plan pending determination of this action." (R12.) Defendants themselves acknowledge the prohibitory nature of this injunction. As the City correctly describes it, "Supreme Court directed defendants to *suspend the charging* of a $15 co-pay for certain primary care and specialist services." City's Br. at 1 (emphasis added).

The cases on which Defendants rely are distinguishable as they all involve requests for mandatory injunctions requiring the defendants to

undertake affirmative acts.[17] Such acts are qualitatively different from the prohibition of co-pays ordered here.

Notably, Defendants have implicitly conceded in this appeal that the preliminary injunction here is not mandatory. Although all mandatory preliminary injunctions involving the City are automatically stayed under CPLR 5519(a)(1), *State v. Town of Haverstraw*, 219 A.D.2d 64, 65 (2d Dep't 1996), Defendants halted the co-pays immediately after the preliminary injunction went into effect.[18] Despite recognizing the fact that mandatory injunctions are automatically stayed (*see* Emblem's Br. at 16-17), Defendants offer no explanation as to why this supposedly mandatory injunction was not. The obvious explanation is that they

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[17] *Second on Second Cafe*, 66 A.D.3d 255 (order requiring installation of equipment and ductwork); *Spectrum Stamford, LLC v. 400 Atl. Title, LLC*, 162 A.D.3d 615 (1st Dep't 2018) (request to replace property manager with new manager of plaintiff's choosing and for current manager to assist with transition); *135 W. Broadway LLC v. 137 W. Broadway Owners Corp.*, 181 A.D.3d 548 (1st Dep't 2020) (order requiring party to vacate property and remove all equipment and materials); *LDC USA Holdings, Inc. v. Taly Diamonds, LLC*, 121 A.D.3d 529 (1st Dep't 2014) (request for specific performance granting plaintiff control over company); *542 Holding Corp. v. Prince Fashions, Inc.*, 57 A.D.3d 414 (1st Dep't 2008) (order requiring removal of alterations and restoration of premises); *St. Paul Fire & Marine Ins. Co. v. York Claims Serv.*, 308 A.D.2d 347 (1st Dep't 2003) (order requiring return of money).

[18] *See* OLR website, https://www.nyc.gov/site/olr/health/retiree/health-retiree-responsibilities-assistance.page. Retirees received letters from Emblem notifying them that it had stopped charging co-pays beginning January 12, 2023, the same day the preliminary injunction took effect.

knew they could not credibly claim that this was a mandatory injunction, and they did not want to face the repercussions of violating a court order.

B. The preliminary injunction does not award the Retirees the ultimate relief they seek.

There is a separate and independent reason why the preliminary injunction here is not subject to a heightened standard: it does not provide "the ultimate relief sought." *St. Paul Fire*, 308 A.D.2d at 349 (reversing preliminary injunction order because it "granted St. Paul the ultimate relief requested in its summons—return of the money alleged converted by York"); *see also LDC USA Holdings*, 121 A.D.3d at 530 (affirming denial of preliminary injunction because it "requested verbatim the ultimate relief sought in the complaint"); *Spectrum Stamford*, 162 A.D.3d at 617 (affirming denial of preliminary injunction because it would have provided the very change of management sought in the complaint); *Societe Anonyme Belge D'Exploitation De La Navigation Aerienne (Sabena) v. Feller*, 112 A.D.2d 837, 839–40 (1st Dep't 1985) ("Ordinarily, injunctive relief will not issue where its effect will be to grant all the relief to which the party may be entitled after a trial.").

The ultimate relief sought in this case is not the temporary reprieve from co-pays awarded by Supreme Court. It is a permanent

injunction, compensatory damages for past co-pays, restitution, disgorgement of profits, statutory damages, treble damages, and punitive damages. (R67.) *See Johnson v. Kay*, 860 F.2d 529, 541 n.4 (2d Cir. 1988) (explaining that preliminary injunction was not subject to heightened standard because "it did not grant [plaintiff] all the relief she sought," including "damages" and "a permanent injunction"); *Eng v. Smith*, 849 F.2d 80, 82 (2d Cir. 1988) (refusing to apply heightened standard to preliminary injunction because it would not provide plaintiffs with the permanent relief they ultimately sought).

Defendants appear to be arguing that a preliminary injunction prohibiting wrongful conduct is improper where, as here, the complaint seeks to permanently enjoin that same conduct. That is not the law. If it were, victims of misconduct would be forced to choose between either immediate temporary relief or delayed permanent relief.

C. The fact that Emblem started charging unlawful co-pays before the preliminary injunction and called that the new "status quo" does not justify a heightened standard.

Because the injunction is clearly prohibitory and does not award the ultimate relief sought, Defendants try to reframe the debate. They claim that the injunction impermissibly altered the "status quo" by

preventing them from continuing to charge co-pays. City's Br. at 7-10; Emblem's Br. at 17-20. This argument is meritless for at least two separate reasons, which are explained below.

1. The standard governing a preliminary injunction does not depend on whether the defendant has already begun the wrongful conduct.

An injunction is not subject to a heightened standard just because it requires a defendant to cease engaging in wrongful conduct it has already begun. *See New York ex. Rel. Spitzer v. Cain*, 418 F. Supp. 2d 457, 472 (S.D.N.Y. 2006) (holding that when an injunction "prevents a defendant from continuing to interfere with a plaintiff's rights," it should be treated as prohibitory, and subject to traditional preliminary injunction standard, even though it alters the current circumstances by "commanding a cessation of the interference"); *Port Washington Teachers' Ass'n v. Bd. of Educ. of Port Washington Union Free Sch. Dist.*, 361 F. Supp. 2d 69, 73 n.1 (E.D.N.Y. 2005) ("[I]n seeking to preliminarily enjoin the School District from continuing to implement its Policy, the Plaintiffs are seeking a prohibitory injunction and thus only the lower standards need be satisfied."). Such an injunction is prohibitory—and

therefore subject to the lower standard—even though it alters the existing state of affairs.

Although courts refer to preliminary injunctions as maintaining "the status quo," that term refers to "the last actual, peaceable uncontested status which preceded the pending controversy." *N. Am. Soccer League, LLC v. United States Soccer Fed'n, Inc.*, 883 F.3d 32, 37 (2d Cir. 2018). For instance, where a preliminary injunction seeks to prohibit an ongoing deprivation of benefits, "the status quo is one in which the plaintiff continues receiving previously granted benefits." *Id.* In other words, when "the defendant has already engaged in the allegedly wrongful conduct," the court must "ascertain the situation and circumstances that existed *before* the occurrence of the events or alleged wrongful acts that gave rise to the litigation." 13 Weinstein-Korn-Miller, *New York Civil Practice: CPLR* ¶ *6301.02* (2021) (emphasis added); *see also United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d. 6, 10 (1st Cir. 1987) (holding that preliminary injunction requiring defendant to resume payment of insurance premiums "preserve[d] the 'pre-grievance' status" of the parties and therefore was not subject to heightened standard). The court can then "restore" that "status quo"—

the one that "existed prior to commencement of defendant's wrongdoing." Vincent C. Alexander, *Practice Commentaries, McKinney's Cons. Laws of N.Y., CPLR 6301:1*. That is precisely what Supreme Court (correctly) did here.

The statute governing preliminary injunctions, CPLR 6301, makes clear that such relief is equally available regardless of whether the defendant has already started to engage in the wrongful conduct at issue. *See* CPLR 6301 (stating that preliminary injunctions are equally available where defendant is already "doing or procuring or suffering to be done" a wrongful act as when "defendant threatens or is about to do" such act, and drawing no distinction between enjoining the "commission or continuance of an act"). The only distinction identified in the statute is whether or not the injunction would "restrain[]" the defendant. *Id*. If it would (as it does here), it is prohibitory.[19]

[19] In a desperate attempt to avoid the operative distinction between mandatory and prohibitory injunctions, the City omits important language from this Court's opinion in *St. Paul Fire*, claiming that it says "*an 'injunction* should not be granted, absent extraordinary circumstances, where the status quo would be disturbed'" and the plaintiff would receive the ultimate relief sought. City's Br. at 7 (quoting *St. Paul Fire*, 308 A.D.2d at 349) (emphasis added). The actual quote is "*[a] mandatory injunction* should not be granted, absent extraordinary circumstances, where the status quo would be disturbed and the plaintiff would receive the ultimate relief sought." Through the deceptive omission of "mandatory," the City falsely suggests that the rule applies to all injunctions, when in fact it only applies to mandatory ones.

This Court routinely affirms prohibitory preliminary injunctions that alter the existing state of affairs by preventing defendants from continuing to interfere with plaintiffs' rights. And it does not subject such injunctions to a heightened standard of review.[20] There is no reason why this case should be any different.

2. There was no opportunity to obtain injunctive relief prior to the sudden imposition of co-pays.

There is an additional reason why Defendants' "status quo" argument fails: due to Defendants' last-minute notice, there was no opportunity to obtain an injunction prior to the imposition of co-pays on January 1, 2022. The first time any Defendant notified Retirees of the

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[20] *See, e.g.*, *61 W. 62 Owners Corp. v. CGM EMP LLC*, 77 A.D.3d 330, 331–32 (1st Dep't 2010), *aff'd as modified and remanded*, 16 N.Y.3d 822 (2011) (ordering preliminary injunction to be issued prohibiting bar from continuing its year-long misuse of its roof deck, and refusing to adopt heightened standard despite alteration of existing circumstances); *Quinones v. Bd. of Managers of Regalwalk Condo. I*, 242 A.D.2d 52, 53 (2d Dep't 1998) (affirming grant of preliminary injunction despite prior commencement of daily fine imposed by defendant); *Bell & Co., P.C. v. Rosen*, 114 A.D.3d 411 (1st Dep't 2014) (affirming preliminary injunction enjoining defendant from continuing to represent clients); *Cent. Park Sightseeing LLC v. New Yorkers for Clean, Livable & Safe Streets, Inc.*, 157 A.D.3d 28, 32 (1st Dep't 2017) (affirming preliminary injunction enjoining defendants from continuing their five-month-long nuisance); *Suchdev v. Grunbaum*, 202 A.D.3d 1126, 1128 (2d Dep't 2022) (requiring defendants to temporarily disable video cameras so as to stop ongoing surveillance); *Martin v. Donghia Assocs., Inc.*, 73 A.D.2d 898, 898 (1st Dep't 1980) (affirming preliminary injunction prohibiting defendant from further engaging in the business of interior decoration and design).

co-pays was in a letter mailed by Emblem on December 17, 2021, which arrived just before Christmas. (R786-87.) Thus, there was no practical way for Retirees to litigate a preliminary injunction motion before January 1.

Defendants may not wait until the last possible moment to disclose unlawful co-pays and then complain that a preliminary injunction should be denied because it would upset the "status quo." Allowing such a maneuver to redound to Defendants' benefit would be grossly unfair and would reward and incentivize inequitable behavior. *See Kimm v. Blue Cross and Blue Shield of Greater New York*, 160 Misc.2d 97, 106 (Sup. Ct. N.Y. Cty. 1993) ("A party may not unilaterally transform a situation, and then be heard to argue that a preliminary injunction cannot be issued because it would change the status quo.").

D. The preliminary injunction would satisfy any standard.

As explained above, because the injunction here is prohibitory and does not provide the ultimate relief sought, no heightened standard applies. However, even if such a standard were to apply, the Retirees would easily satisfy it.

As the Court of Appeals has explained, "[t]here is no question that in a proper case Supreme Court has power as a court of equity to grant a temporary injunction which mandates specific conduct." *McCain v. Koch*, 70 N.Y.2d 109, 116 (1987); *see also* 7 Weinstein–Korn–Miller, N.Y. Civil Practice, § 6301.06 ("[T]here should be no hesitancy about granting a request for a mandatory preliminary injunction whenever a need for one is shown."). Courts regularly grant such injunctions, and often do so in cases where, unlike here, the health of vulnerable individuals is not even at stake.[21]

In order to satisfy the heightened standard applicable to mandatory injunctions that grant ultimate relief, the movant must show that the case presents "unusual" circumstances where the injunction is needed to "preserve" the party's "status." *Second on Second Cafe*, 66 A.D.3d at 264-65. Although Defendants (incorrectly) claim that this heightened

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[21] *See, e.g.*, *Second on Second Cafe*, 66 A.D.3d 255 (ordering installation of equipment and ductwork); *Wilf v. Halpern*, 194 A.D.2d 508 (1st Dep't 1993) (ordering refinancing of partnership debt); *Sure-Fit Plastics L.L.C. v. C & M Plastics Inc.*, 267 A.D.2d 761 (3d Dep't 1999) (ordering return of property); *Chrysler Corp. v. Fedders Corp.*, 63 A.D.2d 567 (1st Dep't 1978) (directing defendant to secure funds for payment of dividends).

standard should apply, they do not even attempt to analyze whether it would be satisfied here.[22] It unquestionably would be.

This case involves an unprecedented violation of the healthcare rights of some 183,000 senior citizens and disabled first responders. Because they live on limited, fixed incomes—tens of thousands subsist on pensions of less than $1,500 a month—and require regular medical attention, many cannot afford the Senior Care co-pays. As a result, prior to this preliminary injunction, they were forced to forego medical care and other basic necessities. *See infra*, Point III.A.

In short, this is an extraordinary case. The continued health and well-being of countless retired City workers depend on this injunction. Accordingly, even if a heightened standard applied here (which it does not), the preliminary injunction would still be warranted.

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

Emblem—and only Emblem—contends that Plaintiffs' breach of contract claim is unlikely to succeed. Specifically, it argues that: (1) the

[22] Because Defendants have not made the argument in their opening brief, they have waived it and cannot make it in their reply brief. *Clairol Dev., LLC v. Vill. of Spencerport*, 100 A.D.3d 1546, 1547 (1st Dep't 2012).

claim is time-barred; and (2) the Contract allows co-pays for medical services. Emblem's Br. at 20-28. Both arguments are meritless, which is likely why Emblem's codefendant, the City, declined to make them.

A. The breach of contract claim is not time-barred.

Plaintiffs' first cause of action is a straightforward breach of contract claim. (R52.) Plaintiffs allege that Emblem's imposition of co-pays violates the Senior Care Contract, of which Retirees are undisputed third-party beneficiaries.[23] The New York State Legislature has provided a 6-year statute of limitations for this cause of action. CPLR 213(2).

Emblem seeks to evade liability by arguing that this claim is time-barred under the 4-month statute of limitations applicable exclusively to Article 78 proceedings. There are at least four fatal flaws to this argument.

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[23] Defendants do not dispute that Retirees have standing as third-party beneficiaries to enforce the Contract. Nor could they. The Court of Appeals recently noted that "hundreds of thousands of City employees and retirees are third-party beneficiaries" of this very Contract. *Plavin v. Grp. Health Inc.*, 35 N.Y.3d 1, 8 (2020). That is because (1) there "exist[s] a valid and binding contract between [the City and Emblem]," (2) that "contract was intended for [Retirees'] benefit," and (3) "the benefit to [Retirees] is sufficiently immediate" and not just "incidental." *Burns Jackson Miller Summit & Spitzer v. Lindner*, 59 N.Y.2d 314, 336 (1983). In fact, the Contract itself states explicitly that Retirees may sue to enforce it. (R159.)

1. Emblem's wrongful conduct cannot be challenged in an Article 78 proceeding.

Contrary to Emblem's contention, the breach of contract claim against Emblem could not be brought in an Article 78 proceeding because it does not "challenge government discretion exercised by the City." Emblem's Br. at 20. The claim is based on *Emblem's* wrongful conduct, not the City's. Plaintiffs have demonstrated that *Emblem* has violated *its* obligations under the Contract *it* negotiated by charging co-pays for the Senior Care plan that *it* administers. Emblem is a private, multi-billion-dollar insurance conglomerate, not an instrument of the City. Its attempt to blame the City for its own contractual breaches should be rejected.

2. A breach of contract claim must be brought in a plenary action, not an Article 78 proceeding.

Even if Plaintiffs were solely challenging government conduct (which they are not), it is black-letter law that such a challenge must be brought in a plenary action with a six-year statute of limitations where, as here, it is based on a breach of contract. As the Court of Appeals has explained, "where the language of the complaint asserts violations of a plaintiff's rights under a contract and the primary thrust of the

allegations is in contract, a plenary action sounding in contract"—not an Article 78 proceeding—"is the appropriate remedy." *Abiele Contracting, Inc. v. New York City Sch. Const. Auth.*, 91 N.Y.2d 1, 8 (1997); *see also id.* at 7-8 ("When the damage allegedly sustained arises from a breach of the contract by a public official or governmental body; then the claim must be resolved through the application of traditional rules of contract law."); *Cromwell Towers Redevelopment Co. v. City of Yonkers*, 41 N.Y.2d 1, 5 (1976) (holding that "an action based on contract" against the city must be brought in plenary action with six-year statute of limitations).

Pursuant to *Abiele*'s clear instructions, this Court and others have consistently refused to apply Article 78's four-month statute of limitations to breach of contract claims. For instance, in *Mitchell v. Bd. of Educ. of City Sch. Dist. of City of N.Y.*, 15 A.D.3d 279 (1st Dep't 2005), a New York City public school teacher sued various municipal defendants claiming that they failed to pay her the salary owed under an agreement. Because the plaintiff alleged a breach of contract, this Court, relying on *Abiele*, "rejected defendants' argument that plaintiff's cause of action [wa]s barred by the four-month statute of limitations applicable to special proceedings under CPLR article 78." 15 A.D.3d at 281.

Likewise, in *Gooshaw v. City of Ogdensburg*, 67 A.D.3d 1288 (3d Dep't 2009), retired municipal workers sued the City of Ogdensburg when it stopped complying with its contractual obligation to pay for all of their healthcare costs. The Third Department reversed the lower court's erroneous dismissal of the action on statute of limitation grounds. It held that Article 78's four-month limitations period was inapplicable because "the 'primary thrust' of petitioners' claim was to enforce a provision in the [contract] that they alleged created a contractual obligation requiring the City to reimburse them for payments they made for Medicare Part B coverage." 67 A.D.3d at 1289 (quoting *Abiele*, 91 N.Y.2d at 8). S*ee also Boyce v. New York City Health & Hosps. Corp.*, 8 A.D.3d 220 (2d Dep't 2004) (applying six-year, and not four-month, statute of limitations because claim sounded in contract); *Kerlikowske v. City of Buffalo*, 305 A.D.2d 997 (4th Dep't 2003) (same).

Emblem contends that the rule requiring contracts to be enforced in plenary actions does not apply to Plaintiffs because they are third-party beneficiaries of the Contract. Emblem's Br. at 23-24. But there is no legal or logical basis for this made-up exception, nor does Emblem offer any. Nowhere did *Abiele* or its progeny state, or even suggest, that the

rule for contract claims does not apply when plaintiffs are enforcing their contractual rights as third-party beneficiaries (nor would such an exception make sense).[24] *Abiele* stated clearly that the *only* question is whether "the complaint asserts violations of a plaintiff's rights under a contract" and "the damage allegedly sustained arises from a breach of the contract." *Abiele*, 91 N.Y.2d at 8. Where, as here, both are true, the claim is properly brought in a plenary action, not an Article 78 proceeding.

3. Emblem waived and is estopped from asserting its statute of limitations defense.

Defendants themselves acknowledged, and assured Retirees, that a breach of contract claim against Emblem need not be brought within four months of the breach. In an attempt to reduce Emblem's exposure under CPLR 213(2)'s six-year statute of limitations, the Contract requires Retirees to bring such a claim within two years of any service for which Emblem violated its payment obligation. Specifically, Section 13.5 of the Certificate of Insurance, which is one of the documents that comprise the Contract, states: "A lawsuit against [Emblem] regarding this Certificate

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[24] Courts have long applied the rule that contracts must be enforced in plenary actions rather than Article 78 proceedings regardless of whether the claim is brought by a contracting party or third-party beneficiary. *See, e.g., Waxenbaum v. Seward Park Hous. Corp.*, 24 Misc. 2d 35, 36 (Sup. Ct. N.Y. Cty. 1960) (holding that contract must be enforced by third-party beneficiary in plenary action, not Article 78 proceeding).

or Group Contract must be started within two years from the date you received the medical or hospital service for which you want [Emblem] to pay." (R159.)

This broad provision squarely applies to this lawsuit. This is a "lawsuit against [Emblem]." It alleges a breach of contract "regarding this Certificate" and the "Group Contract" in which the Certificate is incorporated by reference. The breach of contract claim is based on Emblem's failure "to pay" the full 20% cost of "medical . . . service[s]" required by the Contract. And the lawsuit was "started within two years from the date" of these services.

Thus, even if a breach of contract claim against Emblem were somehow subject to a four-month statute of limitations (which it is not), Emblem would be precluded from asserting such a defense under the doctrines of both estoppel and waiver. *See Nassau Tr. Co. v. Montrose Concrete Prod. Corp.*, 56 N.Y.2d 175, 184 (1982) (explaining elements of each).

4. Emblem's continuing breach of the Contract extends the statute of limitations.

Lastly, because Emblem breached the Contract every time it forced a prohibited co-pay on a Retiree, its statute of limitations defense is also

foreclosed by the "continuing wrong" doctrine. "In contract actions, the doctrine is applied to extend the statute of limitations when the contract imposes a continuing duty on the breaching party." *Henry v. Bank of Am.*, 147 A.D.3d 599, 601 (1st Dep't 2017). Thus, where, as here, a contract provides for continuing performance over a period of time, every breach of that obligation "trigger[s] a new cause of action with its own limitations period." *Moses v. Dunlop*, 155 A.D.3d 466, 468 (1st Dep't 2017) (denying motion to dismiss on timeliness grounds).[25]

B. Plaintiffs are likely to succeed on the merits of their breach of contract claim.

Emblem's contractual obligation to Retirees is simple. The Certificate of Insurance ("COI") states unequivocally that, after a small annual deductible is met, "Medicare will pay 80% of the reasonable charge of your covered service" and "[Emblem] will pay the 20% balance."

[25] *See also, e.g., Bulova Watch Co. v. Celotex Corp.*, 46 N.Y.2d 606, 611 (1979) (holding that claim was "subject to a six-year statute running separately for the damages occasioned each time" contract was breached); *CWCapital Cobalt VR Ltd. v. CWCapital Invs. LLC*, 195 A.D.3d 12, 20 (1st Dep't 2021) (reversing dismissal on statute of limitations grounds because of defendant's continuing failure to comply with contractual obligation); *Guilbert v. Gardner*, 480 F.3d 140, 150 (2d Cir. 2007) (holding that, under New York law, where "a contract requires continuing performance over a period of time, each successive breach may begin the statute of limitations running anew" (collecting cases)).

(R160, 221.)[26] The vast majority (98%) of medical providers in the United States—including virtually all of the doctors Retirees go to—accept the Medicare-approved amount as full payment for a covered service.[27] That means that if a Retiree receives a covered service (*e.g.*, physical therapy) that costs $100 under the Medicare fee schedule, Medicare pays $80 and Emblem is contractually obligated to pay the remaining $20. The Retiree is not supposed to pay anything—and, for decades up until 2022, never did pay anything—for that service.

The imposition of $15 co-pays violates that contractual right. Because of the co-pays, when that Retiree goes in for her $100 physical therapy appointment, she ends up paying $15 and Emblem pays only $5, not the contractually required $20. Emblem does not, and cannot, dispute this basic math.[28] Indeed, Emblem does not, and cannot, deny

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[26] Emblem claims that the COI "is *not the contract*," and is merely "referenced in the Contract." Emblem's Br. at 26 (emphasis in original). Because the Contract requires Emblem to provide the benefits listed in the COI, the COI is part of the Contract. (R80.) Regardless, Emblem's flawed semantics argument is irrelevant, as Emblem does not actually dispute that it is contractually bound by the terms of the COI.

[27] *See* U.S. Centers for Medicare and Medicaid Services, https://www.cms.gov/medicare-participation (reporting that "98% of providers . . . agree to accept Medicare-allowed amounts as payment in full" for all for all Medicare-covered services).

[28] In fact, Defendants have explicitly *acknowledged* that Emblem's 20% payment obligation prohibits co-pays. In the SPD published in 2004, Defendants included a

that, because of the co-pays, it does not pay the contractually required 20% of Medicare-approved costs.

The fact that Emblem is not allowed to charge Retirees co-pays is apparent from other contractual provisions as well. The COI—which governs both Senior Care and CBP—sets forth the "medical benefits" that each "Member shall be entitled to" under the Contract. (R80.) Because cost is a component of "medical benefits," the COI identifies all of the co-pays applicable to each covered service. By listing the co-pays applicable to all services covered under CBP (R132-33, 139, 145, 217, 254), as well as the co-pays applicable to the prescription drug program offered to Retirees (R161-63, 223), while listing *no co-pays* for *any* services covered under Senior Care (R160-61, 221), the Contract clearly intended there to be no co-pays for Senior Care services. *See Wells Fargo Bank v. Aegon USA Inv. Mgmt., LLC*, 198 A.D.3d 156, 162-63 (1st Dep't 2021) (holding that because contract explicitly required subordinate certificates to be written up, but was silent with respect to write-ups for senior certificates,

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chart listing the benefits for each of the healthcare plans available to Medicare-eligible retirees. For plans with co-pays, the chart identified the co-pays applicable to each service. For Senior Care, which had no co-pays for medical services, the chart indicated that there were no co-pays by stating that the plan "[r]eimburses 20% of amount approved by Medicare." *See* 2004 SPD at 50, https://www.osaunion.org/online/nov04/2004HealthBenefits.pdf.

"the drafters clearly intended to express that only subordinate certificates are to be written up"); *Medinol Ltd. v. Bos. Sci. Corp.*, 346 F. Supp. 2d 575, 598 (S.D.N.Y. 2004) (finding the inclusion of language in one section of contract, and exclusion of the same language in another section, to be "purposeful[]" because it would be "hard to believe that the . . . [a]greement would articulate with such precision" in one provision and "permit the construction" through silence elsewhere).

This intent is further confirmed by the fact that, for decades prior to this lawsuit, CBP had co-pays while Senior Care did not. *See Town of Pelham v. City of Mount Vernon*, 304 N.Y. 15, 23 (1952) ("There is no surer way to find out what parties meant, than to see what they have done.").

In the face of this indisputable breach of contract—which the City does not contest—Emblem resorts to fighting a strawman. It argues that "[t]he Certificate of Insurance does not mean, and has never been understood to mean, that members' healthcare benefits under Senior Care are 'free.'" Emblem's Br. at 26. But Plaintiffs are not arguing that the Contract requires Senior Care to be "free." Indeed, Plaintiffs acknowledge that Retirees have to pay an annual $50 deductible before

Senior Care coverage kicks in (R221); that Empire BlueCross BlueShield charges co-pays for certain hospital services, which are governed by a completely separate contract that explicitly permits such co-pays (R39); and that if a Retiree chooses to go to one of the few doctors that charges more than the Medicare-approved amount, or if Medicare is required in a given situation to reduce its payment below 80%, the Retiree will have to pay the difference (R160, 221). But these costs are irrelevant.

Plaintiffs simply argue that the Contract requires Emblem to pay the full 20% of the Medicare-approved amount for covered services. By charging Retirees a $15 co-pay, Emblem pays $15 less than this required amount for every service. This undisputed fact is a clear breach of the Contract, which is why Supreme Court held that Plaintiffs are not just likely to succeed, but "highly likely to succeed." (R11.)

C. Plaintiffs are also likely to succeed on their other claims.

Because Supreme Court correctly concluded that Plaintiffs are "highly likely" to succeed on their breach of contract claim (R11), which is the first count of the Complaint (R52), it had no reason to address Plaintiffs' remaining claims. Those other claims generally relate to Emblem's misrepresentations in the 2020 and 2022 SPDs that there

would be no co-pays for medical services under Senior Care. Because those misrepresentations, and Retirees' reliance on the SPDs, are indisputable, Plaintiffs are also likely to succeed on those claims as well.

However, since Plaintiffs have already demonstrated a likelihood of success on their breach of contract claim, an in-depth analysis of these other claims is unnecessary. Accordingly, for the sake of judicial efficiency, Plaintiffs will not burden the Court here with an analysis of these other claims. Plaintiffs respectfully rely on their arguments below regarding those claims. (*See* R687-92, 694-704, 869-72, 875.)

D. Plaintiffs' high likelihood of success lowers the bar for irreparable harm.

The likelihood of success and irreparable harm requirements operate on a sliding scale. *Republic of Lebanon v. Sotheby's*, 167 A.D.2d 142, 145 (1st Dep't 1990). Thus, where, as here, "the likelihood of success on the merits is great, a movant can show somewhat less in the way of irreparable harm and still garner preliminary injunctive relief." *Vaqueria Tres Monjitas, Inc. v. Irizarry*, 587 F.3d 464, 485 (1st Cir. 2009). That is because the irreparable harm requirement exists to limit the circumstances in which movants obtain relief based on uncertain merit and an undeveloped record. Since Plaintiffs' breach of contract claim

presents a pure and straightforward legal issue, the merits of which can be decided based on the existing record, irreparable harm is less important here.

Although Plaintiffs do not need a lower irreparable harm bar, their unassailable breach of contract claim provides one.

III. PLAINTIFFS AND COUNTLESS OTHER RETIREES WOULD HAVE SUFFERED IRREPARABLE HARM WITHOUT THE INJUNCTION.

Defendants challenge Supreme Court's finding of irreparable harm on two grounds. Emblem's Br. at 11-15; City's Br. at 13-20. First, they contend that the harm at issue is purely monetary and can be adequately compensated with a damages award at the conclusion of this litigation. Second, they claim that the evidence of irreparable harm is insufficient to support the injunction. As discussed below, both arguments are meritless.

A. The co-pays caused Retirees to forego medical care and other necessities and to suffer anxiety, which are well-established forms of irreparable harm.

Those enrolled in Senior Care are all, by definition, elderly or disabled retired City workers or their elderly or disabled spouses. Public records confirm that a large percentage of these individuals live below or

near the federal poverty line, which is $2,096 a month for a one-person household and $2,823 a month for a two-person household.[29] Indeed, over 70,000 retired City workers survive on pensions of less than $1,500 a month; nearly 100,000 survive on less than $2,000; and over 150,000 survive on less than $3,000.[30] Given their advanced age and disabilities, many require regular medical care.

Defendants, who possess comprehensive information about Retirees' health and financial circumstances, do not dispute that tens of thousands subsist on small, fixed incomes while dealing with serious health problems that require frequent medical attention. Nor do they dispute that, prior to the preliminary injunction, these Retirees were incurring co-pays they could not afford.

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[29] *See* 2022-23 Federal Income Guidelines, New York State Department of Health, https://www.health.ny.gov/prevention/nutrition/wic/income_guidelines.htm.

[30] *See* 2021 NYC pension data compiled by the Empire Center, https://www.seethroughny.net/pensions; *see also* New York City Office of the Actuary, Annual Comprehensive Financial Reports for the five New York City Retirement Systems, https://www.nyc.gov/site/actuary/reports/reports.page; Testimony of NYC Comptroller Alan G. Hevesi to the City Council Committee on Government Operations, January 31, 2000, https://www.laguardiawagnerarchive.lagcc.cuny.edu/pages/FileBrowser.aspx?LinkToFile=FILES_DOC/Microfilms/05/011/0000/00001/052429/05.011.0000.00001.052429.10392001.PDF at PDF pp.67-68.

Despite these undisputed facts, Defendants deny any risk of irreparable harm because Retirees will be compensated at the end of this litigation for all of the co-pays they have been unlawfully charged. This argument callously disregards both the suffering caused by the co-pays and controlling caselaw that considers such suffering to be irreparable.

1. The co-pays caused non-monetary suffering.

As detailed in the Verified Complaint and the affidavits submitted in connection with the preliminary injunction motion, countless Retirees, including the named Plaintiffs, were incurring hundreds, and sometimes thousands, of dollars in co-pays for medical services.[31] This is a prohibitive expense for these individuals, who live on limited pensions that must be carefully budgeted to cover the ever-increasing costs of housing, food, medication, transportation, utilities, and other necessities. Based on explicit representations by Defendants and decades of past practice, these Retirees had no reason to expect co-pays for medical services and therefore did not save or budget for this expense.

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[31] *See* R27-30 (detailing the medical visits by each of the five named Plaintiffs, amounting to co-pays of approximately $1,500, $1,470, $1,020, $750, and $540, respectively), R721-42 (detailing co-pays incurred by Plaintiff Janet Kobren and eight other members of Plaintiff NYC Organization of Public Service Retirees, amounting to "the equivalent of four car payments" for one individual, "thousands of dollars" for another, and several hundred dollars for others).

Retirees unable to afford the mounting cost of co-pays were forced to make a heartbreaking—and irreparable—choice: forego needed medical care or do without other necessities. They faced additional irreparable harm in the form of anxiety over their precarious financial circumstances. Such stress poses heightened risks to senior citizens, particularly those with compromised health.[32]

The experience of Retiree Sharon Thomas Dooley is instructive. Her deteriorating health, including a leg infection, necessitated frequent visits to the doctor as well as various medical tests, treatments, procedures, and therapies, each of which required a separate co-pay. (R740-42.) The spiraling costs of the co-pays forced Ms. Dooley to cancel various doctors' appointments, skip physical therapy, and miss prescribed injections. (R741-42.) They also forced her to reduce spending on necessities such as prescription medication, groceries, housing, utilities, air conditioning, and life insurance. (*Id.*)

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[32] Although Retirees could have switched to a Medicare Advantage plan with fewer co-pays starting in 2023, they would have faced potentially more extreme irreparable harm by doing so. By switching to a Medicare Advantage plan, they risked losing access to their medical providers (many of whom do not take Medicare Advantage) and would have been subject to Medicare Advantage's dangerous prior authorization requirements. Regardless, switching plans was not an option considered by the many Retirees who were led to believe, based on the false and misleading 2022 SPD, that Senior Care would have no co-pays in 2023.

Countless Retirees had similar experiences. For example:

- Plaintiff Janet Kobren, a 79-year-old retired teacher living on a $29,000 pension, was forced to cancel and delay doctors' appointments due to the associated co-pays, which she could not afford. (R721-22.) After long postponing a mammogram because of financial difficulty, her doctor recently discovered a dangerous mass that could, and should, have been caught earlier. (R722.)

- Retiree Ann Anesta had to postpone time-sensitive doctor's visits, medical tests, and lab work for herself in order to afford the co-pays for her Retiree husband's cancer treatment. (R733.)

- Retiree Lee Rottenberg had to cancel his physical therapy appointments because he could no longer afford the co-pays. (R739.)

- Retiree Irene Jordan not only had to cancel and delay medical appointments she could not afford, she also had to drastically reduce spending on other necessities in order to afford the medical care she did receive. (R731.) Most notably, she had to limit herself to two meals a day, turn off the heat in her house, refrain from replacing her broken toilet and washing machine, and cease traveling to see her out-of-state great-grandchildren. (*Id.*)

- Retiree Kathy Goldberg could no longer afford the home health aide needed for her Retiree husband, who suffers from Parkinson's disease and sepsis, because of the constant co-pays for his medical care. (R727.) As a result, Ms. Goldberg, who is old and frail, had to assume the physically demanding duties of the home health aide, which resulted in serious injury. (*Id.*)

- Retiree Charles Rosen could no longer afford important prescription medications due to the cost of the co-pays for his cancer treatment. (R735-36.)

- Retiree George Roman, another elderly cancer patient, had to stop paying his electric bill and drastically reduce his spending on food and other essentials in order to afford the co-pays for his radiation. (R737.)

All of these Retirees also experienced significant stress and anxiety over their inability to pay for medical care and other necessities. (*See, e.g.*, R727, 736.)

There are tens of thousands of elderly, infirm Retirees with similar stories. Leading up to—and, in fact, prompting—this litigation, Plaintiff NYC Organization of Public Service Retirees was inundated with cries for help from Retirees who could not afford the co-pays. A handful of members volunteered to serve as named plaintiffs in this class action, and several others submitted affidavits articulating the suffering representative of the entire class. If they had the time and legal obligation to do so, Plaintiffs would have submitted similar affidavits from thousands of other Retirees detailing the medical care and basic necessities they too had to forego because of the co-pays, and the crippling fear and anxiety they too experienced because of this hardship. Plaintiffs would have also submitted affidavits from more fortunate Retirees, who had not yet suffered extreme harm, explaining that they were just one health event away from experiencing it.

2. The suffering caused by the co-pays is irreparable.

The harms these Retirees faced—(1) foregone medical care; (2) deprivation of necessities such as medicine, food, housing, heat, electricity, transportation, and home health aides; and (3) psychological distress—are irreparable because they cannot be remedied after the fact through a damages award. *Klein, Wagner & Morris v. Lawrence A. Klein, P.C.*, 186 A.D.2d 631, 633 (2d Dep't 1992) ("Irreparable injury in this context means any injury for which money damages are insufficient."). An overwhelming body of caselaw confirms this.

First, it is well-settled that where, as here, increased healthcare costs may cause individuals to forego medical care, the harm they face is irreparable. *See, e.g.*, *Civ. Serv. Emps. Ass'n, Inc., Loc. 1000, AFSCME, AFL-CIO v. New York State (Unified Ct. Sys.)*, 73 Misc. 3d 874, 895 (Sup. Ct. Albany Cty. 2021) (holding that irreparable harm exists when individuals are forced to "forgo medical treatment"); *Golden v. Kelsey-Hayes Co.*, 845 F. Supp. 410, 415 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996) (finding irreparable harm because retirees "may be forced to forgo needed medical care" due to increased monthly medical costs of

between $20.50 and $41)[33]; *Schalk v. Teledyne, Inc.*, 751 F. Supp. 1261, 1267–68 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991) (finding irreparable harm because co-pays and other out-of-pocket costs between $180 and $592 a year "might" cause retirees "to forego necessary medical treatment"); *Merkner v. AK Steel Corp.*, 2010 WL 373998, at *5 (S.D. Ohio Jan. 29, 2010) (finding irreparable harm because increased monthly healthcare costs of between $60.73 and $88 would cause retirees to forego medical care)[34]; *Angotti v. Rexam, Inc.*, 2006 WL 1646135, at *15 (N.D. Cal. June 14, 2006) (finding irreparable harm based on retirees' "anticipat[ion] that they will have to postpone or forego" medical care due to cost concerns); *Olson v. Wing*, 281 F. Supp. 2d 476, 486 (E.D.N.Y.), *aff'd*, 66 F. App'x 275 (2d Cir. 2003) (holding that irreparable harm occurs whenever one is "forced by circumstances to forego treatment or medication"); *Zotto v. Scovill, Inc.*, 1985 WL 14176, at *2 (D. Conn. Nov. 7, 1985) (finding irreparable harm because retirees might "forego needed medical treatment if they were required to pay for it"); *Helwig v. Kelsey-*

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[33] These dollar figures come from the preliminary injunction briefing at 1995 WL 17808938.

[34] These dollar figures come from the preliminary injunction briefing at 2009 WL 5002695.

Hayes Co., 857 F. Supp. 1168, 1179 (E.D. Mich. 1994), *aff'd*, 93 F.3d 243 (6th Cir. 1996) (finding irreparable harm because retirees would be "forced to choose between paying for needed medical procedures and paying for basic necessities"). The irreparable nature of foregone medical care is especially true for senior citizens, who are particularly vulnerable.

Second, irreparable harm is commonly found where, as here, fixed-income retirees are forced to reduce spending on necessities in order to pay for increased healthcare costs. *See, e.g., LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48, 55 (2d Cir. 2004) (holding that increased out-of-pocket insurance costs that threatened retirees' "[]ability to purchase life's necessities" caused irreparable harm); *Textron*, 836 F.2d at 8 (explaining that courts have found irreparable harm where retirees must pay for healthcare expenses "out of money that they need for other necessities of life"); *Golden*, 845 F. Supp. at 415 (finding irreparable harm because retirees may not be able to "pay[] for basic necessities" due to increased monthly medical costs as low as $20.50); *Merkner*, 2010 WL 373998, at *5 (holding that increased healthcare costs of as little as $60.73 a month would irreparably harm retirees by forcing them to "ration[]" the "necessities of life"); *Helwig*, 857 F. Supp. at 1179 (finding

irreparable harm because increased healthcare costs would threaten retirees' ability to "pay[] for basic necessities"). This is especially true where, as here, one of the sacrificed necessities is prescription medication.[35]

Finally, the anxiety and distress experienced by Retirees who might not be able to pay for their medical care and other necessities is another widely recognized form of irreparable harm. *See, e.g.*, *Thrower v. Perales*, 138 Misc. 2d 172, 178 (Sup. Ct. N.Y. Cty. 1987) (finding irreparable harm based on "psychological hardship" faced by those in dire financial circumstances); *LaForest*, 376 F.3d at 55 (holding that retirees' "anxiety" over financial "uncertainty" associated with increased healthcare costs constituted irreparable harm); *Angotti*, 2006 WL 1646135, at *16 (finding irreparable harm based on the "reasonabl[e] infer[ence] that all or virtually all retirees will be faced with some increased financial anxiety"); *Merkner*, 2010 WL 373998, at *5 (finding irreparable harm due to retirees' "increased uncertainty and anxiety" relating to increased

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[35] *See, e.g.*, *Becker v. Toia*, 439 F. Supp. 324, 336 (S.D.N.Y. 1977) (holding that imposition of co-pays would cause irreparable harm to plaintiffs who would not be able to afford medication, and explaining that "[t]he injury to those whose health is maintained on the slenderest chemical balance provided through medication is not merely irreparable; it is ultimate").

healthcare costs); *Textron*, 836 F.2d at 8 (finding irreparable harm where "retired workers would likely suffer emotional distress [and] concern about potential financial disaster"); *Schalk*, 751 F. Supp. at 1268 (finding irreparable harm based on retirees' financial "uncertainty").[36]

B. Supreme Court did not abuse its discretion by enjoining all unlawful co-pays.

Next, Defendants argue that even though the co-pays caused an indefinite number of Retirees to forego medical care, reduce spending on necessities, and/or suffer financial anxiety, Supreme Court abused its discretion by granting injunctive relief to all Retirees. Defendants are wrong.

Supreme Court reasonably concluded that the suffering experienced by the four Retiree Plaintiffs and nine Retiree affiants—as described in the Verified Complaint and affidavits (R24, 27-30, 53, 58-60, 62-63, 65, 721-42)—was representative of the harm faced by the broader Retiree community.[37] Contrary to Defendants' erroneous and insensitive

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[36] The City claims that, "as a general rule, no damages will be awarded for the mental distress or emotional trauma that may be caused by a breach of traditional contract." City's Br. at 14 n.6. However, that is irrelevant to the issue of irreparable harm.

[37] Although Supreme Court focused on the suffering described in the affidavits (most of which were submitted by putative class members), courts "may," and often do, "rely primarily on likely harm to the putative class members—rather than harm to the

contention, these were not just a "few members with unique problems." City's Br. at 17. These individuals were selected precisely because of how representative they are: their age range spans decades (late 60s, 70s, and 80s); their pension amounts vary from approximately $1,200 a month (which is below average) to over $7,000 a month (which is far above average);[38] and the medical problems they have experienced are common among the elderly and disabled. Defendants, who bear the burden of demonstrating an abuse of discretion, *Borenstein v. Rochel Properties Inc.*, 176 A.D.2d 171, 172 (1st Dep't 1991), do not point to anything in the record showing that these Retiree Plaintiffs and affiants are outliers.

In short, Supreme Court rationally inferred that countless Retirees faced irreparable harm as a result of the co-pays. In putative class actions involving retiree healthcare, courts routinely grant interim relief to all putative class members based on this same sort of inferential reasoning.

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named plaintiffs—at the preliminary injunction stage." *Strouchler v. Shah*, 891 F. Supp. 2d 504, 517 (S.D.N.Y. 2012).

[38] Retirees' pension amounts are not only in Defendants' possession, they are matters of public record and available online. *See* https://www.seethroughny.net/pensions.

For example, in *United Steelworkers of America v. Textron,* then-Judge (later-Supreme Court Justice) Stephen Breyer, writing on behalf of a unanimous First Circuit, relied on "common sense" and "generally believed facts" about retired union members to affirm a preliminary injunction requiring the defendant to continuing paying the healthcare premiums for all retirees. 836 F.2d 6, 8 (1st Cir. 1987). Specifically, Justice Breyer "t[ook] as true" that: (1) "most retired union members are not rich"; (2) "most live on fixed incomes"; (3) "many will get sick and need medical care"; (4) "some" retirees "may find it difficult" to pay for such care "while others can pay for it only out of money that they need for other necessities of life"; and (5) "retired workers would likely suffer emotional distress, concern about potential financial disaster, and possibly deprivation of life's necessities (in order to keep up in insurance payments)." *Id.* Based on these "generally believed facts"—which apply equally to the present case—Justice Breyer concluded that the plaintiff (a union representing the retirees) had demonstrated irreparable harm to all retirees. *Id.*

Importantly, the only evidence indicating that the "generally believed facts (or facts like them)" actually existed in *Textron* was a single

affidavit by a union president briefly describing problems experienced by a handful of retirees he knew. *Id*. at 8-9. Justice Breyer stated that it was not an abuse of discretion to construe this anecdotal "plight . . . as illustrative of what could occur among all retirees." *Id*. at 9.

The Second Circuit reached a similar conclusion in *LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48 (2d Cir. 2004). In that case, a group of retirees brought a putative class action claiming that a change to their healthcare benefits violated their contractual rights. Relying on the affidavits of six retirees (who were not named plaintiffs), the district court ruled, before class certification, that all 600 putative class members faced irreparable harm due to an increase in the cost of their prescription medication.[39] Like the nine affiants and four named Plaintiffs in the present case, the six affiants in *LaForest* stated that the cost increase impaired their ability to afford medication and purchase "life's necessities," and also caused "anxiety associated with uncertainty." 376 F.3d at 55-56. The Second Circuit affirmed the class-wide finding of

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[39] As in the present case, the cost increase was implemented *before* plaintiffs moved for a preliminary injunction. Notably, that fact did not prompt either the district court or the Second Circuit to apply a heightened standard of review, as Defendants urge this Court to do here.

irreparable harm, holding that it was proper to infer that all retirees faced a risk of similar harm. *Id.* at 56. The court left open the possibility that such an inference could come entirely from the "general facts" noted in *Textron*. *Id.* at 58. But it added that, even if more particularized evidence were required, the six affidavits sufficiently demonstrated that all retirees faced the "probability" of similar harm because: (1) the putative class members were, on average, old; and (2) they had all worked for the same employer or were the surviving spouse of such an individual. *Id.* at 58 & n.7. The same is true in this case.

Courts in numerous other retiree class actions have likewise granted interim relief to the entire class—before class certification—based on similar inferences. *See, e.g.*, *Angotti*, 2006 WL 1646135, at *16 (granting relief to all retirees based on the "reasonabl[e] infer[ence] that all or virtually all retirees will be faced with some increased financial anxiety"); *Merkner*, 2010 WL 373998, at *5 (granting relief to all retirees, despite the varying harm they faced, based on inferences regarding their general financial circumstances and health risks); *Helwig*, 857 F. Supp. at 1179-80 (same, and relying exclusively on affidavits from non-plaintiff

retirees); *Schalk*, 751 F. Supp. at 1267–68 (same); *Golden*, 845 F. Supp. at 415-16 (same).[40]

Although not all 183,000 Retirees faced the same threat of irreparable harm, that did not render it an abuse of discretion for Supreme Court to prohibit all unlawful co-pays. Courts routinely grant interim relief to all impacted individuals even though it is possible that some might be harmed less than others. For example, in *Doe v. Axelrod*, this Court affirmed a preliminary injunction prohibiting the enforcement of a regulation with respect to every affected person because "[p]ossibly many" faced irreparable harm. 136 A.D.2d 410, 415, *aff'd as modified*,

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[40] Although Defendants harp on the fact that the Retiree class has not yet been certified, they do not dispute that class-wide preliminary injunctions are often issued prior to class certification. *See, e.g.*, *Ousmane v. City of New York*, 7 Misc. 3d 1016(A) (Sup. Ct. N.Y. Cty. 2005); *Sharif by Salahuddin v. New York State Educ. Dep't*, 709 F. Supp. 345, 359 (S.D.N.Y. 1989) ("[C]ourts have consistently granted relief that would have a class-wide effect without first certifying a class."). Moreover, Defendants do not, and cannot seriously, dispute that the class here will be certified. The Retirees are a large and easily defined group that is identically situated when it comes to the violation of their contractual (and other) rights, and they cannot afford to seek legal redress individually. Thus, this case is nothing like *Mitchell v. Barrios-Paoli*, on which the City relies. In *Mitchell*, this Court decertified an existing class because a class action was unnecessary and there was no practical way to define the class, and it modified a preliminary injunction because the trial court could not identify any class members facing irreparable harm. 253 A.D.2d 281, 291-92, 295 (1st Dep't 1999). Separately, even if the present case were not a putative class action, Plaintiff NYC Organization of Public Service Retirees would nonetheless have standing to seek injunctive relief on behalf of all Retirees, whose interests it represents. *See, e.g.*, *Cmty. Serv. Soc. v. Cuomo*, 167 A.D.2d 168 (1st Dep't 1990).

73 N.Y.2d 748 (1988). Similarly, in *Schlosser v. United Presbyterian Home at Syosset*, the Second Department affirmed a preliminary injunction prohibiting the defendant from charging increased rent because "[m]any," though not all, of the senior citizens receiving interim relief "cannot afford the scheduled rent increase." 56 A.D.2d 615 (2d Dep't 1977). Likewise, in *Helwig*, the court ordered the defendant to reinstate health insurance benefits to the entire putative class of retirees despite the fact that "some . . . would not necessarily face hardship as a result of reductions in health insurance." 857 F. Supp. at 1180.

As the Second Circuit explained in *LaForest*, the fact that retirees "will suffer varying degrees of harm" from increased healthcare costs does not undermine the propriety of class-wide interim relief. 376 F.3d at 58 n.7. Because it is impractical to assess the potential suffering of every single retiree, courts rely on general inferences about the "probability" of such harm to the putative class in general. *Id*. Here, given that Retirees are all elderly and/or disabled and live on limited, fixed incomes, it is highly probable that many, if not all, would eventually face some form of irreparable harm due to the mounting cost of co-pays.

Defendants seize on the presumed fact that some Retirees required infrequent medical care prior to the preliminary injunction, thereby incurring relatively few co-pays. However, preliminary injunctions are not limited to those who have already suffered irreparable harm. Rather, a movant need only show "the *prospect* of irreparable injury if the provisional relief is withheld." *Axelrod*, 73 N.Y.2d at 750 (emphasis added); *see also Akos Realty Corp. v. Vandemark*, 157 A.D.2d 632 (1st Dep't 1990) (requiring only that "irreparable injury could occur"). Every Retiree is just one health event away from incurring co-pays on a regular basis, and such events, unfortunately, happen frequently to senior citizens (especially during this pandemic, which has ravaged the elderly). Accordingly, even Retirees who managed to avoid drowning in co-pays prior to the preliminary injunction nonetheless faced the threat of irreparable harm. *See Angotti*, 2006 WL 1646135, at *16 (stating that, although one "can[not] be certain" which putative class members "may encounter increased medical needs during the course of the litigation," the mere prospect of such harm was "another factor supporting the Plaintiffs' motion for [class-wide] preliminary relief").

Indeed, unimpeded access to medical treatment is so critical that courts have found that "the mere *threat* of a loss of medical care, even if never realized, constitutes irreparable harm." *Strouchler v. Shah*, 891 F. Supp. 2d 504, 522 (S.D.N.Y. 2012) (emphasis in original). That threat exists for every Retiree who might experience a medical event requiring more care than they can afford.

Lastly, although Defendants complain that the preliminary injunction protects some Retirees who might not have suffered irreparable harm, they do not identify any alternative. The co-pays threatened all 183,000 Retirees with harm, the extent of which varied based on personal circumstances that can change in an instant. Thus, even if Supreme Court could predict that some Retirees would not face irreparable harm (which it could not), there was no way for it to identify those individuals.

IV. THE EQUITIES STRONGLY FAVOR THE RETIREES.

Contrary to Emblem's contention (Emblem's Br. at 29), Supreme Court correctly concluded that the equities favor the Retirees.

Absent injunctive relief, elderly and disabled individuals living pension-check-to-pension-check with debilitating medical problems

would have been forced to forego medical care, reduce spending on basic necessities, and suffer severe distress. By contrast, the *only* harm identified by Emblem in connection with the preliminary injunction was the minor administrative burdens of notifying Retirees that they will not be charged co-pays and updating its IT system to reflect that change. *Id.* These are routine tasks for any insurance company, particularly a well-established, multi-billion-dollar one like Emblem, which regularly tweaks its health insurance plans. Such insignificant administrative burdens cannot possibly outweigh the health and well-being of senior citizens. *See Thrower v. Perales*, 138 Misc. 2d 172, 178 (Sup. Ct. N.Y. Cty. 1987) (finding that equities favored plaintiffs because "[t]heir physical and emotional suffering is far more compelling" than "administrative inconvenience or monetary loss to the [defendant]").[41]

[41] Notably, Emblem ceased imposing the co-pays the same day the preliminary injunction took effect. This shows how minimal of an administrative burden it was. It also means that, at this point, Emblem would *only* suffer harm if this Court were to *vacate* the injunction, since that would force Emblem to take (in reverse) the very administrative steps it bemoans.

CONCLUSION

For the reasons set forth above, the Court should affirm the preliminary injunction prohibiting co-pays for Senior Care medical services.

Dated: March 29, 2023
New York, NY

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PRINTING SPECIFICATIONS STATEMENT
Pursuant to 22 NYCRR § 1250.8(j)

This brief was prepared on a computer, using Century Schoolbook 14 pt. for the body (double-spaced) and Century Schoolbook 12 pt. for the footnotes (single-spaced). According to Microsoft Word, the portions of the brief that must be included in a word count contain 13,867 words.