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

In the Matter of the Application of

LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY, PHYLLIS LIPMAN, on behalf of themselves and others similarly situated, and the NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., on behalf of former New York City public service employees who are now Medicare-eligible Retirees,

Petitioners,

For Judgment Pursuant to CPLR Article 78

- against -

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

Respondents.

Index No.: 158815/2021

PETITIONERS' MEMORANDUM OF LAW IN RESPONSE TO AMICI AND IN FURTHER SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The parties and Amici have fundamentally different views regarding the healthcare rights of elderly and disabled retirees. However, one thing everyone agrees on is that the dispositive statutory issue in this case comes down to a simple question: whether N.Y.C. Administrative Code § 12-126 requires the City to pay up to the statutory cap for any health insurance plan offered to retirees, or only one such plan.[1]

As Petitioners demonstrated in their opening brief, and as further articulated below, the plain text of the statute, legislative history, statutory purpose, past practice, and basic common sense all compel the former interpretation.[2] Accordingly, the City is required to pay for any health insurance plan that costs below the statutory cap, which—as Respondents do not dispute—includes GHI Senior Care.

I. Section 12-126 Requires the City to Pay for *Any* Available Health Insurance Plan Up to the Statutory Cap.

Section 12-126 reads, in pertinent part: "The city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O. on a category basis."

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[1] In light of the Court's stated desire to focus on Section 12-126, Petitioners will stand on their opening brief and their Petition with respect to the other issues in this case.

[2] In support of their contrary interpretation, Amici make legal and factual arguments that either were not made or are contradicted by Respondents. Those arguments are not properly before the Court and should not be considered by it. *See, e.g., United Parcel Serv., Inc. v. Mitchell*, 451 U.S. 56, 61 n. 2 (1981) (refusing to consider argument by amicus because it was not made by the parties); *RSB Bedford Assocs., LLC v. Ricky's Williamsburg, Inc.*, 91 A.D.3d 16, 23 (1st Dep't 2011) (arguments not raised by defendants in their brief are waived and not properly before the court).

N.Y.C. Admin. Code § 12-126(b)(1). Contrary to Amici and Respondents' contention, this requires the City to pay for any health insurance plan offered to retirees, up to the statutory cap of $776 per person per month.[3] *See* Pets' Br. at 7-10.

Under the plain language of the statute, the City's obligation is to pay the entire cost of "health insurance coverage," and not, as Respondents and Amici claim, merely one "health insurance plan." Indeed, when the drafters wanted to refer to a single health insurance plan, they did so expressly. *See* § 12-126(b)(2)(ii) and (iii) (referring to a deceased retiree's "health insurance plan"). Although any single "health insurance plan" provides "health insurance coverage," these two terms have very different scopes. *Rangolan v. Cty. of Nassau*, 96 N.Y.2d 42, 47 (2001) ("[W]here, as here, the Legislature uses different terms in various parts of a statute, courts may reasonably infer that different concepts are intended.").

"Health insurance plan" logically refers to one single plan. "Health insurance coverage" sweeps much more broadly and encompasses the full suite of hospital, surgical, and medical benefits provided to the entire population of "city employees, city retirees, and their dependents" by the various health insurance plans offered

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[3] Amici and Respondents spill much ink arguing that the City need not provide a specific number of premium-free health insurance plans. They are fighting a straw man. Petitioners do not claim that Section 12-126 requires the City to offer a certain number of free plans. They merely argue that the City must pay for those plans it *does* offer, such as Senior Care. In an effort to corral all retirees into the MAP, the City will be closing all of its retiree health insurance plans—except for the MAP and Senior Care—to new enrollees starting on April 1. Those who elect Senior Care, or choose to remain in whatever other plan they are current enrolled in, will have to pay thousands of dollars a year in newly imposed premiums. *See Frequently Asked Questions (FAQs) About the NYC Medicare Advantage Plus Plan*, https://www1.nyc.gov/assets/olr/downloads/pdf/health/ma-faqs-01-21-2022.pdf.

through the NYC Health Benefits Program. *See* § 12-126(a)(iv) (defining "health insurance coverage" as the "**program** of hospital-surgical-medical benefits to be provided by health and hospitalization insurance **contracts** entered into between the city and **companies** providing such health and hospitalization insurance").

The City Council used the term "health insurance coverage" and not "health insurance plan" in Section 12-126(b)(1) because it was requiring the City to pay for any health insurance plan offered by the City, not just one such plan. We know this because, among other reasons, the City Council said so explicitly.

On November 21, 1967, the City Council's Committee on Health and Education published the final version of Local Law No. 120 (later codified at Section 12-126) along with a report summarizing the law. In a definitive answer to the exact question before this Court, the Committee announced:

> **This bill would provide that The City of New York pay for the entire cost of *any* health insurance plan providing for medical and hospitalization coverage of employees and [retirees].**

NYSCEF No. 192, Legislative History of 1967 Local Law No. 120 ("Leg. Hist.") at 9;[4] *see also id.* at 6 (stating the same with respect to an earlier version of the bill). It is difficult to imagine a clearer articulation of legislative intent. *See* Resps.' Reply Br. at 4 (acknowledging that the "interpretation of §12-126 turns on the need to effectuate the intent of the Legislature").

[4] Unless otherwise indicated, all emphasis in this brief has been added, and all internal quotations, citations, and alterations have been omitted.

The City Council's repeated proclamation that the statute requires the City to "pay for the entire cost of ***any*** health insurance plan" removes any possible doubt as to the meaning of Section 12-126. In a desperate attempt to escape these fatal words, the MLC claims that "any" could mean just one. MLC's Br. at 9. It does not. The Court of Appeals has "**repeatedly held that the word 'any' means 'all' or 'every.'"** *People v. Silburn*, 31 N.Y.3d 144, 155 (2018).[5] *See also Scottsdale Ins. Co. v. McGrath*, 506 F. Supp. 3d 216, 224 (S.D.N.Y. 2020) ("Under New York Law, the word "any" means "all" or "every" and imports no limitation."). "[T]he Legislature must be presumed to have been aware of the long-standing judicial construction of that language." *Sheehy v. Big Flats Cmty. Day, Inc.*, 73 N.Y.2d 629, 635 (1989).

Petitioners' interpretation of Section 12-126 is also supported by the history and purpose of the statute. Local Law No. 120 was the product of a years-long movement to provide city employees, retirees, and their dependents a choice of health insurance plans, all of which were paid for by the City (up to a predetermined amount). Indeed, the desire to offer a selection of City-funded plans was so great that in 1965, the City, through Home Rule Request, pushed through state legislation removing then-existing limits to the plans the City could offer and the percentage of funding it could provide. Leg. Hist. at 60-89. The legislation, which amended General Municipal Law § 92-a, allowed the City to "contract for and administer health

[5] These "repeated" holdings of the Court of Appeals began well before Local Law No. 120 was enacted in 1967. *See, e.g., Randall v. Bailey*, 288 N.Y. 280, 285 (1942). In fact, a New York court reiterated that holding just months before the statute was passed. *See Shilbury v. Bd. of Sup'rs of Sullivan Cty.*, 54 Misc. 2d 979, 982 (Sup. Ct. Sullivan Cty. 1967).

insurance **contracts** and **plans** for active and retired city officers and employees and their families," and to "**assume all or any part of the cost of such insurance**, with the balance, if any, to be paid by the employees." *Id*. at 71-72. *See also id*. at 75, 77 (noting that the state law revision would finally allow the City "**to offer a wider choice of health insurance plans**" and "**to assume as an employer expense, all or part of the cost of such plans**").

In short, the City amended General Municipal Law § 92-a so that it could offer and pay (up to a reasonable amount) for a variety of health insurance plans. After the law was amended, the City promptly took full advantage of its new powers: it offered all employees, retirees, and their dependents a choice of health insurance plans and paid for all of them, up to the cost of the HIP plan. *Id*. at 23-30. Importantly, the City resolution announcing these benefits used language nearly identical to that of Local Law No. 120, which was passed shortly thereafter. The resolution reads, in pertinent part:

> Whereas, it is the desire and intent of The City of New York to grant to all of its retired employees . . . a choice of health plans consisting of H.I.P.-Blue Cross, G.H.I.-Blue Cross and Blue Cross-Blue Shield-Major Medical (Metropolitan Life Insurance Company), . . . and ***the City shall assume full payment for such health and hospital insurance, not to exceed 100% of the full cost of H.I.P.-Blue Cross (21-day Plan) on a category basis***, effective April 1, 1967.

Id. at 26. Notably, "health and hospital insurance" referred to ***all three*** of the health insurance plans offered by the City, and the HIP-based dollar cap represented the amount the City was required to pay for ***all*** of those plans.

Given the language of the resolution and the historical events described above (which are referenced throughout the legislative record for Local Law No. 120), it is clear that the statute was meant to codify the contemporaneous practice of paying up to the HIP dollar cap for all of the health insurance plans available under the City's health benefits program.

That practice has continued unabated ever since, as Petitioners have already shown. Pets.' Br. at 13. Indeed, the City has always paid the entire premiums for Senior Care—and certain other plans—because those plans have always cost below the statutory cap. This past practice by itself warrants a ruling in Petitioners' favor. *See Polan v. State of N.Y. Ins. Dep't*, 3 N.Y.3d 54, 63 (2004) (refusing to infer a legislative intent that would upset longstanding past practice regarding provision of disability benefits); *Kolb v. Holling*, 285 N.Y. 104, 113 (1941) (requiring the city of Buffalo to adhere to past payment practice).

Lastly, the inclusion of the statutory cap in Section 12-126 confirms Petitioners' argument. The cap reflects a commitment by the City to provide a specific healthcare *subsidy*—applied towards whichever plan a retiree selects—and not a specific healthcare *plan*.[6] The City correctly recognized that what retirees needed was the ability to choose the health insurance option that was right for them, as well as funding to help them afford that choice. The goal was to "**permit each employee to obtain the form of insurance most advantageous to himself in the light of**

[6] The drafters of Section 12-126 certainly did not intend to provide a Medicare Advantage Plan, a concept that did not even exist until the late 1990s.

his personal circumstances" and "insure that the protection for which **the City pays** is not wasted by disuse." Leg. Hist. at 78.

Respondents do not dispute—in fact, they concede—that the health insurance plans in which the vast majority of Medicare-eligible retirees have always been enrolled (most notably, Senior Care) cost below the statutory cap set by the HIP-HMO plan.[7] The same goes for Amici.[8] Thus, the City must continue to pay the premiums for these plans.

II. Amici's Interpretation of Section 12-126 is Wrong.

Like Respondents, Amici claim that Section 12-126 merely requires the City to pay for one health insurance plan. This argument finds no support in the statutory text, legislative history, or past practice. In other words, it is wrong. It is also undermined by the City and MLC's past statements.

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[7] Resps.' Reply Br. at 2 (referring to "health insurance plans that fall below [the] statutory cap, including GHI-Senior Care"); *id*. at 5 (arguing that the City need not pay for Senior Care "[s]imply because the cost of GHI-Senior Care premiums may fall below the statutory cap"). Nor do Respondents dispute that the current cost of the HIP-HMO plan is approximately $776 per person per month.

[8] The MLC alone argues that the HIP-HMO plan that sets the statutory cap under Section 12-126 somehow does not apply to Medicare-eligible retirees. MLC's Br. at 12. To the extent the MLC is arguing that a different plan sets the cap for this group, they are wrong, as "the statutory yardstick" for everyone is "the H.I.P.-H.M.O. plan." *New York 10-13 Ass'n v. City of New York*, No. 98 CIV. 1425 (JGK), 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999)). Regardless, the MLC does not argue that Senior Care, or any of the other historically free plans, costs the City more than whatever statutory cap it believes is applicable.

A. Prior Court Filings by the City and MLC Undermine Their Argument.

Contradicting its argument in this case, the City has previously asserted in federal court that Section 12-126 requires it to pay for any available health insurance plan up to the statutory cap, not just one such plan. In 2006, the City brought an antitrust action challenging the planned merger of HIP and GHI. In its complaint, and to serve its interests at the time, it stated that under "local law, N.Y.C. Admin. Code § 12-126," the City was "required" to pay for health insurance coverage "up to, but not more than, the rate set by HIP for its HMO plan," and that this obligation applied **"[n]o matter which plan**" was selected. *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006), ECF No. 1 ¶ 30. Although the City happened to be speaking about active employees and non-Medicare-eligible retirees, its concession regarding Section 12-126 applies with equal force to Medicare-eligible retirees, who enjoy the same statutory protections. Section 12-126 makes no distinction between the rights of active employees and retirees, and in fact adds additional protections for Medicare-eligible retirees: the City must reimburse them for their Medicare Part B premiums. And the Moratorium Law, discussed in Petitioners' opening brief, reinforced the requirement that active employees and retirees must be treated the same with respect to healthcare coverage.

The MLC has also discredited itself, though for different reasons. As noted in Petitioners' opening brief, the MLC has a history of misrepresenting the language of Section 12-126. Pets.' Br. at 8 n.5. In December 2019, in an unrelated proceeding, the MLC submitted an amicus brief in opposition to retirees in which it claimed that

Section 12-126 merely "requir[es] the City to provide ***'a fully paid choice***.'" MLC Amicus Brief, *Plavin v. Grp. Health Inc.*, 2019 WL 8128821 at *5 (3d Cir., Dec. 20, 2019) (purporting to quote Section 12-126(b)(1)).[9] As the MLC surely knows, the phrase "a fully paid choice" has never appeared in the statute. Unfortunately, the MLC's misrepresentation of the statute's actual language was not an isolated incident. The MLC repeated that exact same misstatement during court conferences in this case. The fact that the MLC feels the need to "quote" alternate language—instead of the statutory text—speaks volumes about whether that text supports the MLC's self-serving interpretation.[10]

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[9] In *Plavin*, as in the present case, the MLC took a position adverse to retirees (whom the MLC claims to represent). It argued that retirees did not need or deserve the protections of GBL §§ 349 and 350.

[10] The MLC's repeated claim that it represents retirees (MLC's Br. at 2, 17) is outrageous and just as inaccurate as its statements regarding the language of Section 12-126. The MLC did not represent retirees when it entered into a pact with the City to force the MAP on them. The MLC consists of 102 unions, which, under well-settled law (including decisions by the U.S. Supreme Court and the New York Court of Appeals), do not represent retirees. *See* Pets.' Br. at 21. That black-letter principle did not suddenly disappear at the behest of the MLC. The principle exists to protect retirees from a lack of representation and the inherent conflict of interest that exists between union members (who are all active employees) and retirees. That inherent conflict is heightened here, since the $600 million a year in savings from the MAP implementation will result in special payments to individual union welfare funds, with the balance going into a Joint Stabilization Fund. The Joint Stabilization Fund is little more than a slush fund jointly managed by the City and the unions for which there is little—if any—oversight or accountability. Thus, stripping retirees of their statutory right to City-funded healthcare will enrich the unions—an explicit quid pro quo—which explains why the MLC is fighting tooth and nail against retirees in this case.

B. Amici's Textual Analysis is Flawed.

Amici contend that the statutory definition of "health insurance coverage" supports their argument that Section 12-126 requires the City to fund only one health insurance plan. Alliance's Br. at 3, 6-7; MLC's Br. at 6. They are mistaken.

"Health insurance coverage" is defined as "a **program** of hospital-surgical-medical benefits to be provided by health and hospitalization insurance **contracts** entered into between the city and **companies** providing such health and hospitalization insurance." N.Y.C. Admin. Code § 12-126(a)(iv). Amici argue that, because "program" is singular, the term "health insurance coverage" must refer to a single health insurance plan. There are at least two fatal flaws to this argument.

First, a health insurance "program" is not a plan. As explained in virtually every healthcare-related document issued by the City, all health insurance plans are issued through the City's health benefits "program." *See, e.g.*, NYSCEF No. 13 (2020 SPD) at 1; NYSCEF No. 14 (PSC-CUNY CBA) at 160; NYSCEF No. 191 (NYC Office of the Actuary Report) at PDF pp. 1, 2, 7. Further, as noted above in Section I, when the City Council wanted to refer to a health insurance plan, it did so using the term "health insurance plan."

Second, the two words in the definition that relate to the number of health insurance plans—"contracts" and "companies"—are both plural. Although, as Amici

point out, it is possible for a single health insurance plan to be offered by multiple insurance companies pursuant to different contracts, that has never been the norm.[11]

Contemporaneous statutory language confirms that the use of the plural form of "contracts" and "companies" was not accidental. When the City amended General Municipal Law § 92-a in 1965 in order to lift state restrictions on the plans it could offer and the level of funding it could provide, it did so using noticeably different language. The amendment referred to "**a contract or contracts**" with "**one or more insurance companies**." Leg. Hist. at 89. The use of both the singular and plural in General Municipal Law § 92-a, which was designed to give the City maximum contracting flexibility, stands in contrast to the exclusive use of the plural ("**contracts**" and "**companies**") in Section 12-126, which defines the City's payment obligations. This contemporaneous difference in terminology indicates that the City's choice of the plural in Section 12-126 was deliberate, confirming that it intended to pay for multiple health insurance plans, not just one.

C. Amici Distort the Legislative History.

Amici try, unsuccessfully, to reconcile their interpretation of Section 12-126 with the City Council's clear statement that the City is statutorily required to "pay for the entire cost of ***any*** health insurance plan providing for medical and

[11] The City's new MAP plan, for instance, is governed by a single contract. *See* NYSCEF No. 194 (Medicare Advantage Group Agreement). Although Amici claim the City has offered multi-company/multi-contract health insurance plans, they provide no evidence in support of that assertion.

hospitalization coverage of employees and [retirees]." Leg. Hist. at 9. Amici advance two main arguments, neither of which withstands scrutiny.

First, the MLC claims that Merriam-Webster defines "any" as "one or more." MLC's Br. at 9. That is highly misleading for multiple reasons. To begin with, the "one or more" definition cited by the MLC comes from the *second* listed definition. The first notes that "any" means "***every***" and is "**used to indicate one selected without restriction**."[12] Merriam-Webster also provides that "any" means "***all***" and is "**used to indicate a maximum or whole**." These definitions are consistent with nearly a century of jurisprudence from the Court of Appeals, which, as explained above, has "repeatedly held that the word 'any' means 'all' or 'every.'" *Silburn*, 31 N.Y.3d at 155. Further, the "one or more" definition selectively cited by the MLC refers exclusively to circumstances where the total number is "undetermined." Thus, "any" only means "one" if the total number turns out to be one. If the total number (say, of available health insurance plans) turns out to be "more," then "any" means whatever that higher number is. Therefore, the "one or more" definition actually *supports* Petitioners' interpretation that Section 12-126 requires the City to fund every health insurance plan available to retirees.

Amici's second argument is equally unavailing. They claim that Mayor Lindsay's objections to, and the City Council's subsequent revision of, an early draft of Local Law No. 120, which included a reference to "any basic health insurance plan,"

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[12] The entry also notes that "any" can mean "one or another," but only when it is "taken at ***random***" (the offered example being "Ask *any* man you meet"), which clearly does not apply to Section 12-126.

shows that the statute was meant to require payment of only one plan, not any plan. Alliance's Br. at 9-11; MLC's Br. at 10-11. But Mayor Lindsay's concern was simply that there was no predictable limit to what the City might be required to pay under this language, and that concern was resolved through the addition of a statutory cap and a defined term. As detailed below, Mayor Lindsay never objected to the City's obligation to pay for multiple health insurance plans.

In July 1967, the City Council's Committee on Health and Education presented an early version of the bill that would eventually become Local Law No. 120 (which was later codified at Section 12-126). Leg. Hist. at 5-6. It differed from the final version in several respects. Most notably, it lacked a statutory cap and defined terms. It also used the phrase "any basic health insurance plan" instead of "health insurance coverage."

In September 1967, Mayor Lindsay returned the bill with his disapproval because of four "technical defects." *Id*. at 8. Only the second one is relevant here: Mayor Lindsay complained that "[t]he phrase 'basic health insurance plan' is nowhere defined," which would mean the City would face an "open-ended" financial obligation that it "cannot now possibly anticipate." *Id*. Importantly, although the mayor objected to the absence of a definition and to the unpredictable financial exposure, he took no issue with the term "any" or the City's obligation to fund all available plans.

In November 1967, the Committee on Health and Education presented a revised bill that adequately addressed Mayor Lindsay's concerns and was promptly passed into law. It solved the second "technical defect" by defining, and setting a

predictable cap on, the City's financial obligation. Under the revised bill, the City would have to pay the entire cost of "health insurance coverage"—a term defined to include the benefits offered by the various health insurance "companies" participating in the City's health benefits "program"—up to a dollar cap set at the cost of a specific HIP plan. In its report accompanying the final version of the bill, the Committee on Health and Education noted that although certain language had changed, the City's payment obligation had not. Like the original version (*id.* at 6), the enacted bill "would provide that The City of New York pay for the entire cost of ***any*** health insurance plan providing for medical and hospitalization coverage of employees and [retirees]." *Id.* at 9.

In sum, contrary to Amici's contentions, the legislative history conclusively establishes that Section 12-126 requires the City to fund any offered health insurance plan.

D. Amici Do Not and Cannot Dispute the City's Consistent Past Practice of Paying for Senior Care and Other Plans that Cost Below the Statutory Cap.

Despite Amici's attempts to muddy the waters with respect to past practice, the undisputed fact remains that for as long as it has been offered, the Senior Care plan—which the vast majority of retirees have always chosen for their health insurance—has been fully funded by the City. As have various other plans. That is because—as Respondents do not dispute—these plans cost below the statutory cap, which is pegged to the cost of the HIP-HMO plan. As Petitioners have already shown, such longstanding, uninterrupted past practice is "controlling." *Kolb*, 285 N.Y. at 113. The City cannot abandon that controlling practice, and its obligations under

Section 12-126, just because it intends to offer a new Medicare Advantage Plan premium-free.

Amici point to a NYC Office of Labor Relations website showing the premium amounts for various healthcare plans as of January 2022. Alliance's Br. at 12; MLC's Br. at 13. The website confirms that the plans in which virtually all retirees are enrolled (including Senior Care) are premium-free. Although there are premiums associated with a handful of other (highly unpopular) plans, that fact is meaningless for present purposes since the website does not disclose how much it costs the City to offer those plans (*i.e.*, whether it costs more than the statutory cap). Without cost data, there is no way to know whether the City is adequately funding those plans pursuant to its obligations under Section 12-126. And even assuming *arguendo* that it is not, that would hardly undermine Petitioners' past practice argument. It would merely show that, as of last month, the City was failing to sufficiently fund a few plans in which virtually no retirees were enrolled.

The MLC—and only the MLC—claims that the statutory cap for Medicare-eligible retirees should not be pegged to the $776-per-person-per-month HIP-HMO plan. MLC's Br. at 12. The MLC does not say what plan it should be pegged to, if any. However, to the extent the MLC is suggesting that the cap should be pegged to the HIP VIP Premier plan (*id.*), such an argument is both wrong and self-defeating.

It is wrong for four reasons. First, Section 12-126 says "HIP-HMO" not "HIP VIP Premier." Words matter. Second, there has always been one "statutory yardstick" for everyone: "the H.I.P.-H.M.O. plan." *New York 10-13 Ass'n v. City of*

New York, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999). There are different categories of coverage within that plan (individual vs. family), but that is the operative plan. Third, as the City's actuary reports show, HIP VIP Premier has consistently cost the City *less* than Senior Care, yet the City has always fully paid for Senior Care. Thus, HIP VIP Premier never was and could not possibly be the statutory cap. Fourth, starting on April 1, 2022, the City will no longer be offering HIP VIP Premier (or any other HIP plan for that matter) to Medicare-eligible retirees who are not currently enrolled in it.[13] Thus, this plan will soon cease to exist. A nonexistent plan cannot furnish the statutory cap.

Any argument that the statutory cap should be pegged to HIP VIP Premier would also defeat Amici and Respondents' interpretation of Section 12-126. If, as Amici and Respondents contend, the statutory cap does not serve as a payment *mandate* (*i.e.*, a requirement that the City pay for all plans up to the dollar cap), then it could only serve as a payment *prohibition* (*i.e.*, a limitation on the amount the City is allowed to pay towards a health insurance plan). But, as noted above, the City has always paid for Senior Care, which has consistently cost the City more than HIP VIP Premier. Therefore, if the statutory cap were pegged to HIP VIP Premier, then the City would be in violation of Section 12-126 (under Amici and Respondents' interpretation) because it has always paid for a higher-cost plan (Senior Care).

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[13] *Frequently Asked Questions (FAQs) About the NYC Medicare Advantage Plus Plan*, https://www1.nyc.gov/assets/olr/downloads/pdf/health/ma-faqs-01-21-2022.pdf.

III. Petitioners' Interpretation of Section 12-126 is Supported by Former NYC Councilman and Supreme Court Justice Barry Salman.

Petitioners had hoped to shed light on the legislative intent behind Section 12-126 by asking members of the 1967 New York City Council to submit their views regarding the statute they enacted. Unfortunately, Petitioners could not find any who were still alive. The earliest-serving councilmember Petitioners could locate was the Honorable Barry Salman, who sat on the City Council from 1970-1977 and later served as a New York State Supreme Court Justice from 1990 through 2016. Justice Salman was on the City Council when Section 12-126 was amended in 1970, 1971, 1972, 1973, and 1974,[14] and he served alongside councilmembers who enacted the statute in 1967.

Justice Salman has studied Section 12-126 and its legislative history and he has concluded that, contrary to Amici's arguments, the statute unambiguously requires the City to fund any health insurance plan selected by retirees, not just one such plan. *See* Gardener Aff. Ex. 1. Because of Justice Salman's uniquely relevant insight and experience, and because this is an issue of first impression, Petitioners offer his attached affirmation for the Court's consideration.[15]

[14] These amendments concerned increases to the Medicare Part B premium.

[15] Petitioners will be compensating Justice Salman for the brief time he spent crafting his affidavit based on his normal hourly rate.

IV. Amici and Respondents Could Get Most of What They Wanted if They Weren't So Greedy.

The complete lack of empathy for elderly and disabled retirees is evident from Amici and Respondents' filings and from their hasty MAP implementation. In their eagerness to unlock a $600 million treasure chest, they peddled lies and misinformation about the MAP, including that it is just as good as Senior Care; rushed to automatically enroll hundreds of thousands of retirees without giving them adequate time or information; imposed prohibitively expensive premiums on anyone who opts out; violated retirees' exclusive, contractual entitlement to choose and change their health insurance plan; drastically reduced the number of health plan options; and trampled retirees' statutory and contractual rights.

It did not, and does not, have to be this way. The political pressure to tap federal funds attached to Medicare Advantage programs is, understandably, very powerful. And were they not so greedy, the City and Amici could create a Medicare Advantage plan that is actually as good as, or even better than, Senior Care, which retirees could voluntarily opt into without financial coercion. If the plan were in fact as good as, or better than, Senior Care, retirees would flock to it. The City might have to subsidize the plan to make it high-quality, but because it would be funded by the federal government, the City and Amici would still unlock federal funding and "save" a fortune. Not a $600 million fortune, but very likely above $300 million annually. Meanwhile, the City would be honoring its statutory, contractual, and moral commitments to its most vulnerable retirees.

The City and Amici chose not to pursue this path. They still can, and hopefully will.

CONCLUSION

The elderly and disabled retirees who brought this lawsuit served, and in many cases risked their lives for, this City. Overworked and underpaid, they scrimped and saved during their income-earning years so that they would have enough to live on in their old age. They budgeted for retirement based on the assumption that the City would continue to comply with its statutory and contractual obligations and pay for their health insurance coverage, just as it had for the generations that came before them. Now that they are retired—and in many cases living pension-check-to-pension-check with significant health issues—it is too late for them to adjust their savings and investment strategy.

Many cannot afford to now pay thousands of dollars a year to keep their longstanding health insurance, which they desperately need. By forcing them to do so, however, the City stands to save, and Amici stand to make, hundreds of millions of dollars a year. The callousness and greed on display is shocking.[16] It is also unlawful. Section 12-126 requires the City to continue paying for Senior Care and other plans that have always cost below the statutory cap.

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[16] Sadly, the unethical pursuit of profits appears to be part of the Alliance's business model. Anthem, the primary member of the Alliance, was recently sued by the Justice Department for engaging in a multi-million-dollar fraud against the Centers for Medicare and Medicaid Services. *See U.S. v. Anthem, Inc.*, 20 Civ. 2593 (SDNY, March 26, 2020.

If, as Respondents and Amici contend, changed circumstances justify the imposition of these unprecedented premiums, the correct response is to amend Section 12-126, not disregard it.

Petitioners reiterate their request that the Court compel Respondents to comply with Section 12-126 by continuing to pay the entire premiums for Senior Care and any other plan that costs below the statutory cap.

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WORD COUNT CERTIFICATION

Pursuant to 22 N.Y.C.R.R. § 202.8-b, the undersigned hereby certifies that this memorandum of law complies with the word count limitation in that rule. Exclusive of the exempted portions, the memorandum of law contains 5,509 words. As permitted, the undersigned has relied upon the word count feature of a word processing system in preparing this certificate.

New York, New York
February 23, 2022

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