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New York Supreme Court

APPELLATE DIVISION — FIRST DEPARTMENT

Case No. 2022-01006

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

Petitioners-Respondents,

against

RENEE CAMPION, CITY OF NEW YORK OFFICE OF LABOR RELATIONS and CITY OF NEW YORK,

Respondents-Appellants.

BRIEF FOR PETITIONERS-RESPONDENTS

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QUESTION PRESENTED

This appeal presents the following question:

Does N.Y.C. Administrative Code § 12-126 require the City of New York to pay up to the statutory cap for retired City workers' health insurance coverage regardless of which healthcare plan they select?

The trial court correctly answered this question in the affirmative.

Petitioners-Respondents the NYC Organization of Public Service Retirees, Inc., Lisa Flanzraich, Benay Waitzman, Linda Woolverton, Ed Ferington, Merri Turk Lasky, and Phyllis Lipman (together, "Petitioners") respectfully submit this brief in opposition to the appeal of Renee Campion, the New York City Office of Labor Relations ("OLR"), and the City of New York (together, "the City") from a Decision and Order entered in the Supreme Court, New York County on March 3, 2022 granting in part Petitioners' Article 78 Petition.[1]

PRELIMINARY STATEMENT

Retired New York City firefighters, paramedics, cops, teachers, and other civil servants dedicated their lives to—and in many cases risked their lives for—this City. They did not do so for the money. Indeed, most would have made a better living, and enjoyed a safer and healthier existence, in the private sector. They sacrificed their bank accounts and their physical well-being in order to serve their fellow New Yorkers and

[1] Petitioners originally noticed a cross-appeal to vindicate their rights under the Retiree Health Insurance Moratorium Act. However, the cross-appeal arguments were predicated on specific features of a healthcare plan—known as the NYC Medicare Advantage Plus Plan ("MAPP")—that, as of July 2022, no longer exists. In light of these changed circumstances, Petitioners withdrew their cross-appeal. If and when the City finds a replacement for the MAPP, Petitioners reserve the right to assert in a future proceeding any arguments they could have made in a cross-appeal.

secure the retirement benefits guaranteed by the City. Chief among those benefits is a choice of health insurance paid for by the City, for life.

The primary source of that health insurance guarantee is N.Y.C. Administrative Code § 12-126 ("Section 12-126"), which requires the City to pay up to a specified amount (the "statutory cap") for any health insurance plan a retiree chooses. That includes plans specifically designed for Medicare-eligible (*i.e.*, elderly and/or disabled) retirees like Petitioners.

The decades-long sacrifices made by City workers pays off when they retire. Unlike their wealthier private-sector counterparts, they can rest easy knowing that the City must continue to fund their choice of health insurance, just as it has done for every municipal retiree for the past half-century. Given that many elderly and disabled retirees (especially 9/11 first responders) live pension-check-to-pension-check with serious health conditions, the right to receive continued care from their doctors, funded by the City, is a financial and psychological lifeline.

That lifeline, however, is now under assault. In a callous and unprecedented attempt to cut costs (despite a historic multi-billion-dollar budget surplus), the City announced that it will cease funding Medicare-

eligible retirees' existing health insurance even though such insurance costs less than the statutory cap. This withdrawal of funding is part of the City's effort to force these elderly and disabled individuals into a significantly worse type of health insurance—called "Medicare Advantage"—that is paid for by the federal government. If retirees refuse to accept the City's new Medicare Advantage plan, they will be charged thousands of dollars a year—a prohibitive expense for most—to retain their existing health insurance and the doctors, timely care, and superior benefits that come with it, which many desperately need.

The Medicare Advantage plan that the City originally tried to force on retirees—known as the NYC Medicare Advantage Plus Plan ("MAPP")—had serious flaws that are common to Medicare Advantage. Most notably: it had a limited network of doctors; it would have prevented retirees from receiving treatments ordered by their doctors unless and until those treatments were authorized by the private insurance conglomerate (known as the "Alliance") administering the MAPP; and it would have inflicted severe financial liability on individuals whose out-of-network doctors forgot to obtain this prior authorization or failed to navigate the gauntlet of other procedural hurdles erected by the

insurance conglomerate to maximize profits. In July 2022, during the pendency of this appeal, the Alliance dissolved and the MAPP ceased to exist.[2] The City is looking to find a replacement Medicare Advantage plan, but no deal has yet been reached.

Despite the significant problems with Medicare Advantage, the City claims that forcing it on retirees will help alleviate the increasing costs of healthcare. However, the City's planned healthcare overhaul would not actually reduce those costs; it would merely shift them onto retirees and the federal government. Moreover, as the Director of Budget Review for the New York City Independent Budget Office testified, the City's plan to withdraw funding for retiree healthcare would not even save taxpayers any money.[3] That is because all cost savings are slated to go to "the administration and the unions" (with no "accountability or direct oversight"), not the City budget.[4] Regardless, no budget concerns

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[2] *See* NYC Office of Labor Relations, Health Benefits Program Announcement, https://www1.nyc.gov/site/olr/health/retiree/health-retiree-responsibilities-assistance.page.

[3] Testimony of Jonathan Rosenberg to the New York City Council Committee on Civil Service and Labor Regarding Changes to Municipal Retirees' Healthcare Plan, October 28, 2021, https://ibo.nyc.ny.us/iboreports/medicare-advantage-testimony-october-2021.pdf, at 1 (explaining how the MAPP would "provide[] the city with no actual budgetary savings").

[4] *Id.*

could ever justify the City's disregard for its clear statutory obligation to continue paying for retirees' existing health insurance.

In its desperation to cease funding retiree health insurance, the City resorts to making baseless legal arguments.

First, the City contends that Section 12-126 only requires it to pay up to the statutory cap for *one* of the health insurance plans offered to retirees (which the City has decided will be the new Medicare Advantage plan). However, the statutory text, legislative history, and past practice decisively refute that argument. Section 12-126 clearly requires the City to pay up to the statutory cap for *any* offered health insurance plan. The City Council explicitly said so when it passed the statute, a fact the City fails to disclose in its brief. And the City itself has explicitly and repeatedly acknowledged this statutory obligation in the past, another inconvenient fact the City neglects to mention. As explained below, the City omits and distorts conclusive proof of the statute's meaning, including the very words of the statute, which require the City to subsidize all of the plans offered by the various health insurance "companies" participating in the City's health benefits "program." N.Y.C. Admin. Code § 12-126(a)(iv).

Second, the City contends—for the first time here on appeal, and beyond the scope of its own "Question Presented"—that there is a separate statutory cap for Medicare-eligible retirees, and that this cap is somehow below the cost of their existing health insurance, which the City has always fully funded. Astoundingly, the City goes so far as to claim, without any evidence, that the statutory cap for these elderly and disabled individuals is a mere $7.50 per person per month (as compared to $776 per person per month for everyone else), which is a fraction of what the City has historically paid for their health insurance. Because the City failed to make this fact-intensive argument in any of its briefs or oral arguments below, it is not properly before this Court. Regardless, the argument is wrong, as it is contradicted by undisputed evidence, basic logic, and past practice.

In short, the City's arguments regarding Section 12-126 are meritless, as the trial court correctly held. Accordingly, this Court should affirm the order below requiring the City to continue paying for retirees' existing health insurance.

NATURE OF THE ACTION

A. Background

1. The City attempts to shift its obligation to pay for retiree healthcare entirely onto retirees and the federal government.

Section 12-126 requires the City to provide and pay for health insurance coverage for active and retired City employees and their dependents. This case involves the City's statutory obligation to its approximately 250,000 Medicare-eligible retirees. (R34). Although these individuals are enrolled in Medicare, the City provides supplemental coverage through one of several "Medigap" plans, which pay for the substantial portion of healthcare costs that Medicare does not cover. (R29). For decades, the overwhelming majority of Medicare-eligible City retirees have enrolled in a Medigap plan known as "Senior Care," which is fully paid for by the City and jointly administered by Group Health Incorporated ("GHI") and Empire BlueCross BlueShield. (R29, 151).

As the City correctly notes, the "nationwide phenomenon" of increasing healthcare costs has for "decades" strained the coffers of public and private employers alike, and the City is no exception.[5] City's Br. 3,

[5] Although healthcare costs have steadily increased, so has the City's ability to meet those costs. Indeed, the City recently announced that it has the highest cash reserves

17. In recent years, the City and the Municipal Labor Committee ("MLC")—an advisory group of municipal union representatives—began exploring various cost-cutting initiatives, including eliminating City-funded health insurance for Medicare-eligible retirees. (R29). These elderly and disabled individuals are easy targets: they are not represented by the unions and their healthcare needs are quite costly.[6]

In July 2021, the City announced that, starting in 2022, it would seek to drastically reduce costs by forcing Medicare-eligible retirees off of Senior Care and other City-funded plans and onto a Medicare Advantage plan paid for by the federal government. (R29). This planned healthcare overhaul had three components.

First, all Medicare-eligible retirees would be automatically removed from their City-funded health insurance plans and placed into a new federally funded Medicare Advantage plan known as the NYC Medicare

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in history, including a $3.7 billion surplus on a nearly $100 billion budget. *See Review of the Financial Plan of the City of New York* (March 2022), https://www.osc.state.ny.us/files/reports/osdc/pdf/report-19-2022.pdf, at 12; *The City of New York Preliminary Budget Fiscal Year 2023*, https://www1.nyc.gov/assets/omb/downloads/pdf/sum2-22.pdf at 4.

[6] It is black-letter law that unions—and, by extension, the MLC—do not represent retirees. *See, e.g.*, *Kolbe v. Tibbetts*, 22 N.Y.3d 344, 354 (2013) ("once employees retire, they are no longer represented by the union"); *Agor v. Board of Educ., Northeastern Clinton Cent. Sch. Dist.*, 115 A.D.3d 1047, 1049 (3d Dep't 2014) ("employees are no longer represented by the union upon retirement").

Advantage Plus Plan ("MAPP"), which was to be jointly administered by the "Alliance" of EmblemHealth and Anthem BlueCross BlueShield. (R30-31).

Second, those who did not wish to be enrolled in the MAPP would, for the first time ever, have to cover the cost of their own health insurance, which, for those on Senior Care, was $191.57 per person per month (or approximately $2,300 a year). (*Id.*).

Third, going forward, the only health insurance options available to new Medicare-eligible retirees would be the MAPP and Senior Care.[7] The vast array of City-funded plans that had long been offered to Medicare-eligible retirees would cease to exist.

In sum, under the City's planned healthcare overhaul, the cost of health insurance coverage for Medicare-eligible retirees would be borne by the federal government or the retirees themselves, meaning the City would avoid financial responsibility.[8]

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[7] *See Frequently Asked Questions (FAQs) About the NYC Medicare Advantage Plus Plan*, https://www1.nyc.gov/assets/olr/downloads/pdf/health/ma-faqs-11-19-21.pdf at 1, 3.

[8] The City would continue to pay for retirees' Medicare Part B premiums, which is a separate (and undisputed) statutory obligation that is not at issue in this case.

2. The MAPP, like Medicare Advantage plans in general, offered inferior healthcare benefits.

Although the City repeatedly asserts in its appeal brief that the MAPP would have provided retirees "improve[d]," "new and better" benefits than those offered under Senior Care, *see, e.g.*, City Br. 1, 3, 18, 19, the facts belie that boast.

First, the network of healthcare providers that would have accepted the MAPP was limited. Although virtually all doctors and hospitals accept Medicare—and, by extension, Medigap plans such as Senior Care—many refuse to participate in Medicare Advantage plans. That is because the reimbursement rate is set by the private insurer administering the plan, and that rate is often significantly less than what Medicare pays.[9] The City and the Alliance boldly predicted that only nine percent of retirees' doctors would not accept the MAPP. (R1958; NYSCEF No. 148 at 13). However, the record is replete with affidavits from both retirees and their healthcare providers revealing that countless doctors either had not yet made up their minds or had

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

preemptively announced that they would not accept the MAPP. (R843-74, 914-17, 923-69; NYSCEF No. 124).

Second, unlike Senior Care and other Medigap plans, the MAPP (like all Medicare Advantage plans) would have imposed dangerous "prior authorization" requirements on scores of life-saving medical procedures and diagnostic tests. (R1434-82; NYSCEF No. 149). Prior authorization is a process by which the private insurer—which maximizes profits by minimizing payments—will not provide coverage unless and until it determines that a procedure ordered by one's doctor is "medically necessary."[10] Not surprisingly, prior authorization protocols regularly delay and prevent diagnosis and treatment, creating life-threatening risks for patients. In a recent physician survey conducted by the American Medical Association, 94% of respondents reported that prior authorization requirements caused delays in necessary treatment, and, as a result, 30% reported "serious adverse events" that required medical intervention, 18% reported a life-threatening event, and 9% reported a serious disability or permanent bodily damage. (R1104). In

[10] *See generally* HealthCare.gov, Glossary, Preauthorization, https://www.healthcare.gov/glossary/preauthorization/.

April 2022, the U.S. Department of Health and Human Services ("HHS") released a damning report revealing "widespread and persistent problems related to inappropriate denials of services and payment" caused by Medicare Advantage prior authorization requirements.[11] The report noted "millions of denials each year," which are so routine and unwarranted that 75% of denials that are appealed get reversed.[12] The problem has become so extreme that Congress recently proposed bipartisan legislation to address it.[13]

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

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[11] U.S. Dep't of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* ("HHS Report"), April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf at PDF p. 2.

[12] *Id*. at PDF pp. 2, 9.

[13] *See* Improving Seniors' Timely Access to Care Act, https://www.congress.gov/bill/117th-congress/house-bill/3173.

- A 72-year-old woman presented with a cancerous tumor in her breast.[14] Her Medicare Advantage plan denied the necessary surgery ordered by her doctor. That decision was reversed only after HHS happened to intervene.
- An 81-year-old with uterine cancer was improperly denied a CT scan that was "needed to determine the stage of the cancer, whether it had spread, and to determine the appropriate course of treatment."[15]
- A Medicare Advantage plan refused to admit a 67-year-old stroke victim to an inpatient rehabilitation facility even though he presented with an "acute right-sided ischemic stroke and [was] seen at the emergency department with new onset slurred speech."[16] The man "had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore," according to the Medicare Benefit Policy Manual,

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

[15] *Id.*, Example D421.

[16] *Id.*, Example D270.

"should have been under the frequent supervision of a rehabilitation physician."[17]

As the HHS report and numerous other reports[18] have shown, these sorts of unjustified denials of coverage occur on a regular basis due to the prior authorization requirements imposed by Medicare Advantage plans.

Third, for retirees whose doctors were outside of the limited MAPP network, it was the retirees' responsibility to ensure that their doctors sought and obtained prior authorization before receiving treatments subject to prior authorization requirements. (R696). If prior authorization was not sought in advance for a given treatment that required it, and the claim associated with that treatment was later deemed by the insurance Alliance not to be medically necessary, the retiree would have had to shoulder the entire cost of the treatment, which could be thousands of dollars. (*Id*.).

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[17] *Id*.

[18] *See also, e.g.*, Maya Kaufman and Natalie Sachmech, *Rising denial rates impeding Medicare Advantage enrollees' access to inpatient rehab, providers say*, CRAINE'S, May 23, 2022, https://www.crainsnewyork.com/health-pulse/rising-denial-rates-impeding-medicare-advantage-enrollees-access-inpatient-rehab.

For these and other reasons, retirees strenuously objected to the City's plan to force them into the MAPP or any other Medicare Advantage plan.

3. The City failed to include retirees in negotiations about the MAPP, misled retirees about the MAPP's coverage, and refused to address retirees' concerns.

The problems with the MAPP were compounded by the City's exclusion and deception of retirees throughout its healthcare overhaul process, which the trial court found to be "irrational, . . . arbitrary and capricious." (NYSCEF No. 112 at 2). The City kept retirees in the dark, affirmatively misled them, and rushed to automatically enroll them in the MAPP because it knew they were unlikely to enroll on their own if they were adequately informed.

First, the City completely shut retirees out of its negotiations regarding the MAPP. Those negotiations occurred exclusively between the City and the MLC, which is comprised of representatives of municipal labor unions that are responsible for negotiating on behalf of active employees, not retirees. (R29-30, 171-72, 445, 483, 595, 735, 839, 916-18, 1051-52). *See Kolbe v. Tibbetts*, 22 N.Y.3d 344, 354 (2013) ("once employees retire, they are no longer represented by the union"). The City

and the MLC essentially sold out retirees in order to enrich themselves.[19] The City made no effort to negotiate with or solicit comments from retirees, nor did it hold public hearings regarding its drastic overhaul of retiree healthcare benefits. (R920); *see* City's Br. 17-19 (describing the decision-making process between the City and the MLC). The first time most retirees learned of the MAPP was after it was announced as a *fait accompli* on the City's Office of Labor Relations website on July 14, 2021. (R30).

Second, even after the MAPP was publicly announced, the City repeatedly failed to provide retirees with accurate information—and in many cases, any information at all—about the plan and how it would affect them. For example, the City and the Alliance misrepresented that all healthcare providers who accepted Medicare would participate in the MAPP. (R682, 690, 914). And they repeatedly and incorrectly identified specific providers as accepting the MAPP even though many of these providers had not agreed to participate in it and many had never even heard of it. (R843-74, 914-17, 923-69; NYSCEF No. 124).

[19] The savings obtained by forcing retirees into a Medicare Advantage plan will result in special payments to union "welfare" (*i.e.*, slush) funds, which explains why the MLC has fought tooth and nail against retirees in this case. (NYSCEF No. 208 at 9).

The City and the Alliance also failed to explain the extent of the MAPP's prior authorization requirements and the serious problems those requirements would create. (R843-74, 915-17, 970-980). The enrollment guide sent to retirees identified only a handful of services that required prior authorization. (R696-704; NYSCEF No. 85 at 16-24). However, a 300-page "Evidence of Coverage" document that the City later buried online revealed scores of additional procedures subject to prior authorization. (R1739-87; *see also* NYSCEF No. 120 at 15-24).

Moreover, the City and its representatives consistently failed to provide clear and consistent answers to various questions by retirees regarding the MAPP. (R916-17, 1053-1103). Worse yet, the City failed to provide many retirees with any information whatsoever regarding the MAPP, thus preventing them from making an informed decision about their healthcare future before the original October 31, 2021 deadline to opt out of the MAPP. (R916-18, 981-1052).

Finally, when retirees began to organize and raise concerns about the MAPP, the City ignored them and summarily rejected their requests. Several weeks after the MAPP implementation plan was announced, a group of elderly and disabled retirees from across city agencies came

together (despite innumerable obstacles presented by the pandemic) and formed a non-profit called the NYC Organization of Public Service Retirees in order to advocate for their healthcare rights. (R911). Although the City derisively characterizes the organization as being formed "for litigation purposes," it was created in direct response to the City's actions well before this lawsuit was filed, and it has amassed thousands of members. (City's Br. 1; R911).

On September 13, 2021, the NYC Organization of Public Service Retirees asked for a meeting with the Office of Labor Relations ("OLR") to address retirees' concerns about having to pay thousands of dollars a year to retain their existing (and previously free) health insurance, which the City is obligated to fund under Section 12-126. (R839). OLR Commissioner Renee Campion responded several days later, brushing aside the retirees' concerns and refusing their request to meet. She explained that the "implementation of this program is already underway" and that "there are no plans to change that." (R841). She told the retirees "that [Section 12-126] does not include any reference to the Senior Care plan," and was therefore irrelevant, and she argued that if

retirees just gave the MAPP a "try" they would "find the program to be a dramatic improvement in their benefits." (*Id.*).

This action was filed several days later.

B. Procedural History

On September 26, 2021, Petitioners filed this Article 78 proceeding in New York County Supreme Court. (NYSCEF Nos. 1-23). The petition asserted that the City's attempt to force retirees to enroll in the MAPP by charging them thousands of dollars a year to keep their existing health insurance was unlawful, arbitrary, and capricious.[20] (*Id.*).

On October 3, 2021, Petitioners filed an amended petition (the "Petition") that included new information showing that the City continued to mislead retirees about the MAPP. (R26-82). Simultaneously, Petitioners moved for a preliminary injunction to prevent the City from requiring retirees to decide whether to opt out of the MAPP by October 31, 2021. (R13-16).

The City opposed the preliminary injunction motion on October 15, and on October 19—one day before the scheduled hearing on the

[20] The petition argued that the City's actions violated Section 12-126, the Retiree Health Insurance Moratorium Act, and retirees' contractual rights. (*Id.*).

motion—it cross-moved to dismiss the Petition, improperly listing a return date of the following day. (R1121; NYSCEF Nos. 66-76). Petitioners filed a reply in support of their preliminary injunction motion on October 19 but did not have an opportunity to respond to the City's procedurally improper cross-motion before the next day's hearing. (NYSCEF No. 97). Separately, the MLC moved to intervene in the case, which Petitioners opposed. (NYSCEF Nos. 59-62, 83).

The trial court heard argument on the pending motions on October 20, 2021. The following day, the court granted Petitioners' preliminary injunction motion and denied the MLC's motion to intervene.[21] (NYSCEF No. 112). The preliminary injunction order focused on the myriad flaws in the City's MAPP implementation process, noting, for example, that "it is undisputed that much of the [MAPP's] terms," and the data regarding doctor and hospital participation, "are still unsettled and unclear." (*Id*. at 3). Because it would have been impossible for retirees to make an informed decision about their health insurance coverage without such basic information, the court concluded that "the implementation of [the

[21] The court did not address the City's cross-motion to dismiss, which it noted in a subsequent email to the parties was procedurally defective.

MAPP] is irrational and if the petitioners and similarly situated individuals are required to opt-in or out of a medical program by the October 31, 2021 deadline there would certainly be irreparable harm." (*Id.*). The court did not rule on the legality of the City's plan to stop paying for retirees' existing health insurance, although the parties had briefed that issue. (NYSCEF Nos. 63, 72, 79, 97).

On December 14, 2021—following additional hearings regarding the City's flawed implementation of the MAPP—the trial court extended the preliminary injunction to April 1, 2022 and ordered the City to submit biweekly reports on the progress of its curative measures. (NYSCEF No. 166 at 2). The court added that it would rule on the overall merits of the Petition—*i.e.*, whether the City could force retirees into the MAPP by withdrawing funding for their existing health insurance—once the MAPP misinformation problems were resolved. (*Id.*).

A few weeks later, the trial court scheduled a hearing for late February 2022 to address the ultimate merits of the Petition. Specifically, the Court wrote:

> I ask for the parties to be prepared to discuss the overall Article 78 issue on that date aside from the roll out. There has been some argument on this, but as I will look to make an

> ultimate decision on this sooner rather than later, I would appreciate it if all sides were ready to discuss this issue.

(SR11).

In order to assist the court—particularly in light of the avalanche of evidence and arguments submitted by the parties over the previous four months—Petitioners promptly filed a memorandum of law, which they styled as a "motion for summary judgment," that succinctly distilled the issues remaining in the case along with the relevant facts and legal authorities. (R1127-29; NYSCEF Nos. 185-97). *See Gerardi v. Vill. of Scarsdale*, 26 Misc. 3d 1239(A) n.1 (Sup. Ct. Westchester Cty. 2009), *aff'd*, 71 A.D.3d 895 (2d Dep't 2010) (deeming it proper for a petitioner to submit a "'motion for summary judgment' as a further elucidation of his argument under Article 78"). Petitioners' submission also responded to the arguments raised in the City's stale cross-motion to dismiss, which had been filed months earlier without a valid return date.

On February 1, the City wrote to the trial court and complained that Petitioners' "summary judgment" filing was incorrectly labeled. (NYSCEF No. 198). Nonetheless, the City supported the court ruling on the overall merits of the Petition based on the existing record, and asked that oral argument be held at the next regularly scheduled conference

(February 7), rather than at the end of the month (as originally planned). The City wrote: "We believe that it is in the best interest of the parties for the conference on February 7, 2022 to include oral argument on the merits of the Petition. Respondents respectfully reassert their strong desire for a determinative ruling as soon as possible . . . ." (*Id.*). Petitioners were similarly eager for the court to "conduct a full and fair hearing on the merits" of the Petition, but asked that the hearing remain calendared for late February. (NYSCEF No. 199). The court notified the parties by email that it would "set a definitive date to discuss the merits" at the February 7 status conference. (SR1). At that conference, the court informed the parties that oral argument on the merits of the Petition would be held on February 28 and that a ruling on the Petition would follow promptly thereafter.

On February 4, the City submitted a memorandum of law in response to Petitioners' summary judgment filing. (NYSCEF No. 201). In addition, on February 15, both the MLC and the Alliance—the two non-parties with significant financial interests in the MAPP's implementation—filed *amicus curiae* briefs in support of the City, to

which Petitioners responded on February 23. (NYSCEF Nos. 205, 206, 208).

On February 28, the trial court heard argument on the merits of the Petition. As the court had warned in advance, the exclusive focus of the hearing was on Section 12-126.

At no time during the February 28 hearing did the City argue (as it does here on appeal) that that statutory cap was lower than what Petitioners had alleged—and proven—in their Petition. Indeed, not once in the nearly six months of motion practice, court conferences, and oral arguments leading up to the hearing did the City contest the $776 per-person-per-month statutory cap amount or dispute that this amount exceeded the cost of the health insurance plans the City had always paid for (including Senior Care). Nor did the City argue (as it does here on appeal) that there was a reduced statutory cap unique to Medicare-eligible retirees, much less that this cap was a mere $7.50 (as it now claims).

The City's silence is especially noteworthy given Petitioners' repeated statements in their filings and at oral argument that the statutory cap amount was undisputed. (*See, e.g.*, R1955; NYSCEF No.

189 at 8, 14; NYSCEF No. 208 at 1, 7, 14). In fact, not only did the City *not dispute* the statutory cap, it *affirmatively conceded* that the statutory cap exceeded the cost of Senior Care and the other plans paid for by the City. (*See, e.g.*, NYSCEF No. 201 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")).[22]

The City's sole argument with respect to Section 12-126 was that the law merely requires it to pay up to the statutory cap for *one* health insurance plan—not *any* health insurance plan—and that it could satisfy this obligation by offering the MAPP to retirees for free, even though it would cease funding all of their other health insurance options. (*See* NYSCEF No. 79 at 3; NYSCEF No. 201 at 2-6). According to the City, "[s]imply because the cost of [retirees' existing health insurance] may fall

[22] The only time the City raised any issue regarding the statutory cap was on March 2, *after* briefing and oral argument on the merits of the Petition. (R1970-71). In a frantic, one-and-a-half page letter filed at the close of business the day before the trial court had announced it would issue its ruling on the Petition, the City claimed for the first time, and without citation to any evidence, that the statutory cap for Medicare-eligible retirees was $7.50, drastically below the cost of Senior Care. (*Id.*). The City offered no explanation for why it had never raised this issue before or how the statutory cap could suddenly be so low.

below the statutory cap does not shift the obligation to the City." (NYSCEF No. 201 at 5).

On March 3, 2022, the trial court granted the Petition in significant part. (R7-10). As relevant here, the court held that under Section 12-126, the City must continue to pay for any health insurance plan that costs below the statutory cap, including the $191-per-person-per-month Senior Care. (R9-10). The court explicitly rejected the City's sole argument that Section 12-126 only requires the City to pay up to the statutory cap for one plan. (R9).

On March 4, the City appealed, and on March 15, Petitioners cross-appealed. (R3-6). Because the cross-appeal was predicated on specific features of the MAPP, which no longer exists, Petitioners have withdrawn their cross-appeal.

ARGUMENT

Article 78 of the CPLR allows members of the public to bring suit to compel the City "to perform a duty enjoined upon it by law." CPLR 7803(1). Section 12-126 imposes a clear duty upon the City that it seeks to no longer perform.

Section 12-126 requires the City to pay up to a specific amount (the statutory cap) for any offered health insurance plan, not just one plan of the City's choosing. As discussed below, the statutory text, legislative history, and past practice compel that conclusion. In fact, the drafters of the statute explicitly said so. When publishing the final version of the bill that would become Section 12-126, the City Council announced: "*This bill would provide that The City of New York pay for the entire cost of* <u>*any*</u> *health insurance plan providing for medical and hospitalization coverage of employees and [retirees].*" (R1327 (emphasis added)). Up until this litigation, the City had always acknowledged this fact. Indeed, the City has repeatedly stated that Section 12-126 requires it to pay up to the statutory cap for any and all health insurance plans. And since Section 12-126 was enacted over half a century ago, it has consistently provided the statutory subsidy for all available health insurance plans, resulting in a wide selection of free healthcare options.

Accordingly, the trial court was correct to order the City to continue paying up to the statutory cap for retirees' existing health insurance. The City's attempt to dispute the statutory cap for the first time here on

appeal should be rejected, as it is both procedurally improper and meritless.

I. THE TRIAL COURT CORRECTLY HELD THAT THE CITY MUST CONTINUE PAYING FOR RETIREES' EXISTING HEALTH INSURANCE.

The City provides its employees, retirees, and their dependents a choice of health insurance plans, all of which are offered through the City's "Health Benefits Program." (R83-166). Section 12-126 requires the City to pay for such health insurance coverage up to a maximum amount, specifically the cost of the HIP-HMO plan based on its two categories of coverage: individual and family. In other words, if an employee or retiree seeks coverage for herself individually, the City must pay for her chosen health insurance up to the cost of individual coverage under the HIP-HMO plan. If, however, the employee or retiree seeks coverage for herself and her dependents, the City must pay for their chosen health insurance up to the cost of family coverage under the HIP-HMO plan.

Section 12-126 states in relevant 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." N.Y.C. Admin. Code § 12-126(b)(1). "Health insurance coverage" is defined to encompass all of the plans offered by the various health insurance "companies" participating in the City's health benefits "program." *Id.* § 12-126(a)(iv).

The City argues that the trial court erred in two respects: *first*, by interpreting Section 12-126 to mean that the City must pay up to the statutory cap for any health insurance plan offered through the City's Health Benefits Program, not just the MAPP; and *second*, by finding that the health insurance that retirees currently receive for free costs below the statutory cap, a fact the City did not dispute. City's Br. 26. As explained below, both arguments are meritless.

A. Section 12-126 requires the City to pay up to the statutory cap for any health insurance plan offered through the City's Health Benefits Program, not just one such plan.

Contrary to the City's contention (City's Br. 28-34), Section 12-126 requires the City to pay up to the statutory cap for *any* health insurance plan offered through the City's Health Benefits Program, not just one plan of the City's choosing. In prior litigation, the City acknowledged this fact, asserting that its obligation to pay for health insurance coverage "up to, but not more than, the rate set by HIP for its HMO plan" applies "*[n]o*

matter which plan" an individual selects. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006).[23] The New York City Law Department reiterated this position in 2016, explaining that Section 12-126 "requir[es] that the City, with respect to *any offered plan*, pay up to the [statutory cap]." (NYSCEF No. 227 at 3).

The Court should reject the City's sudden change of position in this litigation, as it is decisively refuted by the plain text of the statute, the City Council's statement of legislative intent, the legislative history, and the City's past practice. Each of these tools of statutory construction is addressed below.

1. Section 12-126 was the product of a years-long movement to provide municipal employees and retirees a choice of City-funded health insurance plans.

When interpreting statutes, the Court of Appeals has "repeatedly recognized that legislative intent is the great and controlling principle, and the proper judicial function is to discern and apply the will of the enactors." *ATM One, LLC v. Landaverde*, 2 N.Y.3d 472, 476-77 (2004).

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

Accordingly, "inquiry must be made of the spirit and purpose of the legislation, which requires examination of the statutory context of the provision as well as its legislative history." *Id.* at 477.

To that end, before delving into the statutory text, it is helpful to first place Section 12-126 in its historical context. That context demonstrates that Section 12-126 was meant to codify the City's contemporaneous practice of paying up to a generous amount for any and all health insurance plans offered through the City's Health Benefits Program.

Section 12-126 was originally enacted in 1967 through Local Law No. 120. (R1319-21). It 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. In fact, 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. (R1378-1407). The legislation, which amended General Municipal Law § 92-a, allowed the City to "contract for and administer

health 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." (R1389-90; *see also* R1393, 1395 (noting that the state law amendment 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 for a variety of health insurance plans.

Immediately after § 92-a was amended in 1965, the City promptly took full advantage of its new powers: it offered all City employees, retirees, and their dependents a "program" (R1354) of health insurance plans, and paid for all of them up to the cost of a specific plan administered by the insurance company HIP. (R1341-48). Importantly, the 1965 City resolution announcing these benefits used language nearly identical to that of Section 12-126, which was passed shortly thereafter. The resolution—Resolution Calendar No. 292 ("Resolution 292")—stated 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.

(R1344; *see also* R1343-44 (stating the same with respect to City employees and the dependents of City employees and retirees)).[24] Notably, the term "such 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.

By passing Resolution 292, the City recognized that what people needed was an opportunity to choose a health insurance plan that was right for them and City funding to enable that choice. The goal was to "permit each [person] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances" and "insure that the protection for which the City pays is not wasted by disuse." (R1396). The

[24] Resolution 292 continued and extended the healthcare benefits addressed in an earlier resolution (Resolution Calendar No. 155), which used nearly identical language. (R1350-52).

goal was decidedly not for the City to select one lone health insurance plan to fund.

2. Section 12-126 codified the City's obligation to provide and pay for a choice of health insurance plans.

Section 12-126 was enacted through Local Law No. 120 in 1967 to codify the essential protections of Resolution 292 by requiring the City to fund any health insurance plan offered to City employees, retirees, or their dependents. (*See* R1327 (noting the codification)); NYSCEF No. 227 at 2 (City acknowledgment that Section 12-126 "was based" on Resolution 292); *New York 10-13 Ass'n v. City of New York*, No. 98-CV-1425, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (stating that "the statute was enacted pursuant to Resolution Cal. No. 292").

Echoing Resolution 292, Local Law No. 120 stated in relevant part: "The city of New York 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.-Blue Cross (21-day plan) on a category basis." (R1321). This statutory mandate remains in effect today, with one minor tweak: in 1984, the HIP-Blue Cross 21-day plan became defunct and was replaced by the HIP-HMO plan. (R1141).

There is no question that the intent behind Local Law No. 120 was for the City to pay up to the statutory cap for *any* health insurance plan offered through the City's Health Benefits Program, not just one such plan. Indeed, the City Council explicitly said so.

On November 21, 1967, the City Council's Committee on Health and Education published the final version of Local Law No. 120 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 <u>any</u> health insurance plan providing for medical and hospitalization coverage of employees and [retirees].*" (R1327).[25]

Although the City concedes that the Court must "give effect to the intention of the Legislature," City's Br. 28, it conspicuously fails to mention this clear articulation of legislative intent, which is irreconcilable with the City's flawed interpretation of the statute. The omission is telling.

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[25] 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) (emphasis in original). These "repeated" holdings began well before Local Law No. 120 was enacted in 1967. *See, e.g., Randall v. Bailey*, 288 N.Y. 280, 285 (1942). "[T]he [City Council] 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).

3. The plain text of Section 12-126 makes clear that the City must fund any health insurance plan offered through the City's Health Benefits Program.

The statute's plain text confirms the City's obligation to fund all available health insurance plans, not just one. The statute requires the City to pay for "health insurance coverage," and not, as the City claims, merely one health insurance plan. When the drafters of the statute wanted to refer to a single health insurance plan, they did so expressly. *See* N.Y.C. Admin. Code § 12-126(b)(2)(ii) and (iii) (referring to a deceased retiree's "health insurance plan").[26] By describing the City's healthcare payment obligation in the broadest possible terms ("health insurance coverage"), the City Council clearly meant more than just one "health insurance plan." *See 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.").

Indeed, the statutory definition of "health insurance coverage" proves this. Section 12-126 defines that term as the entire "program of

[26] Although a "health insurance plan" provides "health insurance coverage" to a person enrolled in that plan, the latter term sweeps much more broadly than the former.

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). As explained below, these underlined words refer to the multiple health insurance plans offered by the City.

First, the word "program" is used throughout the legislative record to refer to the entire array of health insurance plans offered by the City. (*See, e.g.*, R1354 (repeatedly referring to the "program" of multiple health insurance plans offered by the City, and using the term "health insurance coverage" in connection with the City's obligation to pay for all of these plans)). The state statute that authorized Section 12-126 likewise uses the term "program" to encompass all offered plans. *See* N.Y. State General City Law § 20(29-b) (empowering cities to pay certain costs for "any retired officer or employee who . . . is enrolled in a choice of *health plans program* offered by the city"). Further, as explained in every healthcare-related document published by the City, all of the health insurance plans available to City employees, retirees, and their dependents are offered through the City's Health Benefits "Program." (*See, e.g.*, R83, 87, 100, 110, 113, 330, 391, 1162, 1409). Thus, contrary

to the City's contention (City's Br. 30), the use of the singular term "program" does not suggest that the City's payment obligation is limited to one health insurance plan. Just the opposite: it confirms that the City must fund all of the health insurance plans offered through its Health Benefits Program.

Second, the two words in the definition that relate to the number of health insurance plans—"contracts" and "companies"—are both plural. Although the City claims it is possible for a single health insurance plan to be offered by multiple insurance companies pursuant to different contracts with the City, Petitioners are not aware of any multi-company/multi-contract plans, and the City does not (and did not below) identify any evidence of such plans.[27]

Comparative statutory analysis supports Petitioners' interpretation. When General Municipal Law § 92-a was amended in order to lift state restrictions on the plans the City could offer and the level of funding it could provide, noticeably different language was used. The amendment referred to a "contract or contracts" with "one or more insurance companies." (R1407). The use of both the singular and plural

[27] The MAPP, for instance, was governed by a single contract. (R1419).

in General Municipal Law § 92-a, which was designed to give the City maximum contracting flexibility, stands in stark 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.

Finally, the phrase "such health and hospitalization insurance" is virtually identical to the phrase used in Resolution 292 to refer to all of the health insurance plans offered by the City. (R1344 (referring to the various plans offered and paid for by the City as "such health and hospital insurance")). By citing and mirroring the language of Resolution 292—which took effect just months before Section 12-126 was enacted—the City Council clearly sought to invoke its requirements.

In sum, the statutory text and legislative history compel the conclusion reached by the trial court: Section 12-126 requires the City to

pay up to the statutory cap for any and all health insurance plans, not just one plan.[28]

4. The City's prior statements and uninterrupted past practice support the trial court's holding.

For over half a century—since Section 12-126 was passed in 1967—the City itself has consistently construed the law as requiring it to pay up to the statutory cap for any and all health insurance plans, not just one plan.

In fact, the City has explicitly said so. In a 2006 antitrust action challenging the planned merger of HIP and GHI, the City stated that under "local law, N.Y.C. Admin. Code § 12-126," it is "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 applies "*[n]o matter which plan*" is selected. Compl., ECF No. 1 ¶ 30, *City of New York v. Grp. Health Inc.*, No. 06-CV-13122 (S.D.N.Y. Nov. 13, 2006).[29] Similarly, in a 2016

[28] A former State Supreme Court justice and City Councilmember—who sat on the City Council right after Section 12-126 was enacted and who voted on various amendments to the statute—submitted a sworn affidavit stating that the City Council intended the City to pay up to the statutory cap for any and all health insurance plans. (R1967).

[29] 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.

letter to the Office of Labor Relations, the New York City Law Department wrote that Section 12-126 "requir[es] that the City, with respect to *any offered plan*, pay up to the [statutory cap]." (NYSCEF No. 227 at 3). The City is not free to assert the opposite position in this case just because it is now convenient to do so.

Decades of past practice confirm the City's obligation to pay up to the statutory cap for any and all health insurance plans. From 1967 (when Section 12-126 was originally enacted) to the present, the City has always fully paid for plans that cost below the statutory cap, including Senior Care. The record is replete with uncontested evidence of this.[30] Indeed, this fact is so widely recognized the Second Circuit Court of Appeals has taken note of it. *See City of New York v. Grp. Health Inc.*, 649 F.3d 151, 154 (2d Cir. 2011) (stating that "[u]nder municipal law," "the City pays the entire premium" for the statutory cap "HIP plan" as

[30] *See, e.g.*, R1411 (1983 Health Benefits Handbook listing the various health insurance plans (including HIP and GHI) available to retirees, and explaining that all such health insurance coverage "is paid in full by the City of New York"); R1733 (2004 United Federation of Teachers Pension Handbook noting that health insurance coverage under HIP, GHI, and various other plans is fully paid for by the City); R1283, 1294 (2021 New York City Office of the Actuary Report noting the multiple health insurance plans (including GHI Senior Care) paid for by the City, and explaining that retirees must pay for health insurance coverage only if, and to the extent, the plan they select is more expensive than the statutory cap set by the HIP-HMO plan).

well as all other plans up to "the cost of the HIP plan"). The City does not, and cannot, point to any contrary evidence.

This longstanding and uninterrupted past practice by the City constitutes an additional binding concession regarding the meaning of Section 12-126. *See Kolb v. Holling*, 285 N.Y. 104, 113 (1941) (assigning "controlling" weight to the city of Buffalo's past payment practice and requiring it to continue making payments pursuant to that practice); *cf. 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).

5. The City's arguments are meritless.

As demonstrated above, the plain text, legislative history, past practice, and prior City concessions all compel the conclusion reached by the trial court: Section 12-126 requires the City to pay up to the statutory cap for any available health insurance plan, not just the City's preferred plan. In the face of this overwhelming evidence regarding the meaning of Section 12-126, the City resorts to making meritless arguments based on (i) the wrong legal standard, (ii) distortions of the historical record,

and (iii) flawed policy analysis. Each of these erroneous arguments is addressed below.

First, the City argues that its interpretation of Section 12-126 should be upheld so long as it is merely "rational" or "reasonable," and cites to CPLR 7803(3). City's Br. 33-34. That is not the standard of review here. CPLR 7803(3) applies to cases involving discretionary agency determinations where judicial deference is owed based on the agency's unique competence. This case, unlike those relied on by the City, involves a simple issue of statutory interpretation under CPLR 7803(1), where the question is whether the City "failed to perform a duty enjoined upon it by law." *See Krug v. City of Buffalo*, 34 N.Y.3d 1094, 1095 n.1 (2019) (explaining that the deferential standard under CPLR 7803(3) does not govern cases involving CPLR 7803(1)). Because "the question at issue" here "is one of pure statutory interpretation," this Court applies "de novo review" and does not accord the City any deference whatsoever. *City of New York v. Comm'r of Lab.*, 100 A.D.3d 519, 520 (1st Dep't 2012); *see also Claim of Gruber*, 89 N.Y.2d 225, 231-32 (1996) ("[W]here the question is one of pure statutory reading and analysis, dependent only on accurate apprehension of legislative intent, there is

little basis to rely on any special competence or expertise of the administrative agency. In such circumstances, the judiciary need not accord any deference to the agency's determination, and is free to ascertain the proper interpretation from the statutory language and legislative intent.").[31]

Second, the City contends that then-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," shows that the statute was meant to require payment of only one plan, not any plan. City's Br. 31. But Mayor Lindsay's concern was simply that there was no predictable limit to what the City might be required to pay under the statute, and that concern was fully resolved through the addition of a statutory cap and a definitions section. As detailed below, Mayor Lindsay never objected to the City's obligation to pay for multiple health insurance plans, and the City Council never altered that obligation.

[31] Even if the City's interpretation were entitled to deference—which it is not—it has for decades construed Section 12-126 as requiring it to pay up to the statutory cap for all available health insurance plans. That longstanding interpretation—not the self-serving, contrary one the City has advanced in this one litigation—would control.

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). (R1323-24). 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." (R1326). 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," nor with 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 generous limit 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 obligation to fund all available plans had not. Like the original version (R1324), 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]." (R1327).[32] Mayor Lindsay approved.

Finally, the City claims that "[i]t is hard to see why the City Council would create a regime that does not require any alternative plans to be offered, but compels the City to pay for them if they are offered, subject

[32] The City argues that the City Council could have conveyed its intent more clearly in the statutory text. City's Br. 31-32. The same, however, could be said for virtually any law. The meaning of Section 12-126 is unambiguous and the legislative intent could not be clearer. That there are alternative ways for the City to have expressed its intent is of no moment.

only to the law's monetary cap." City's Br. 32. There is nothing confusing or illogical about the City Council's intent: it sought to protect those who served the City—many of whom sacrificed their health, safety, and potential for higher earnings—by paying for their chosen health insurance plan up to a generous amount. Section 12-126 reflected a collective desire for the City to "assume" payment for a "choice of health plans," with the goal being to "permit each [current and retired municipal worker] to obtain the form of insurance most advantageous to himself in the light of his personal circumstances" and "insure that the protection for which the City pays is not wasted by disuse." (R1344, 1396). Given the diverse healthcare needs and personal circumstances of the municipal employee and retiree community, the wisdom of such a policy is plain.

The City Council had no reason to require the City to offer a specific number of health insurance plans because the City had no incentive to unduly limit that number: its payment obligation would remain the same regardless. When Section 12-126 was enacted in 1967, its drafters could not have predicted that the City might someday seek to limit retirees' healthcare options in order to force them into a federally funded Medicare

Advantage plan. Such plans did not exist at the time.[33] And, regardless, such a maneuver would violate the clear purpose of the statute, which was for the City to fund a choice of health insurance options.

6. A federally funded Medicare Advantage plan cannot satisfy Section 12-126 even under the City's flawed interpretation of the statute.

Even assuming, arguendo, that Section 12-126 required the City to pay for only one health insurance plan (which it does not), the City would still be in violation of the statute. That is because the lone premium-free plan it seeks to offer, a Medicare Advantage plan, will be federally funded; the City will not be paying for it. Indeed, as reflected in the draft contract between the City and the insurance Alliance offering the MAPP, with the exception of a small administrative payment in the first year ($7.50 per person per month for marketing), the City would not pay a dime for the plan. (R1642). Therefore, contrary to the City's contention, a federally funded Medicare Advantage plan cannot possibly satisfy Section 12-126's requirement that "[t]he *city* will pay the entire cost of health insurance coverage."

[33] Medicare Advantage plans first appeared in the late 1990s.

B. The City's argument regarding the statutory cap is both unpreserved and meritless.

In addition to its flawed statutory interpretation argument, the City also attempts to manufacture an unpreserved factual dispute. Specifically, the City contends that the statutory cap for Medicare-eligible retirees is not the $776-per-person-per-month amount applicable to everyone else, but is instead a mere $7.50, which the City claims (without any evidentiary support) is the current cost of the HIP VIP Premier plan. City's Br. 34-35.

This argument should be rejected for multiple independent reasons.

1. The City waived its statutory cap argument.

First, the City did not make this fact-intensive argument in any of its trial court briefs or during any of the countless hearings and oral arguments below. It had ample opportunity to do so.

The trial court proceedings featured nearly six months of briefing and hearings on the legality of the City's overhaul of retiree healthcare benefits. During that time, Petitioners repeatedly and accurately reported to the court (verbally and in writing) that there was no dispute between the parties regarding the statutory cap amount. (*See, e.g.*, NYSCEF No. 189 at 8, 14; NYSCEF No. 208 at 1, 7, 14; R1955). Despite

Petitioners' clearly stated position regarding the statutory cap amount and its undisputed status, the City not only failed to object, but affirmatively conceded the point.[34]

Moreover, after raising no objections to Petitioners' statutory cap analysis, the City urged the trial court to issue a final ruling "on the merits" of the Petition based on the arguments and undisputed facts presented in the parties' dispositive motion papers.[35] (NYSCEF No. 198). And that is exactly what the trial court announced it would do—and ultimately did—given the lack of any factual dispute. (SR 1, 11).[36]

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[34] *See, e.g.*, NYSCEF No. 201 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").

[35] *See* Black's Law Dictionary (11th ed. 2019) (defining "on the merits" as "delivered after the court has heard and evaluated the evidence and the parties' substantive arguments," and "hearing on the merits" as "a formal proceeding before a judge" who "makes a final decision in the case").

[36] The City notes in passing that the trial court ruled on the Petition "without affording the City an opportunity to answer." City's Br. 25. Importantly, however, the City does not claim that this was procedurally improper. That is because it was not. Not only did the City take full advantage of its ample opportunity to present its arguments and defenses, it affirmatively asked the trial court to rule on the merits of the Petition based on the existing undisputed record. *See Hawkins v. New York City Transit Auth.*, 26 A.D.3d 169, 170 (1st Dep't 2006) ("It was not necessary for the court to grant respondents leave to serve an answer under CPLR 7804(f) before ruling on the merits, since they had already clearly stated their relevant arguments, leaving no material facts in dispute."); *cf. Wein v. City of New York*, 36 N.Y.2d 610, 620-21 (1975) (party who specifically asked for judgment pursuant to statute converting dismissal motion into summary judgment motion could not be heard to complain that court treated motion in that fashion).

The City's failure to dispute the statutory cap below prevents it from doing so here on appeal. Indeed, it is well settled that where, as here, a party fails to raise an argument in its trial court briefs—in fact, in its *opening* trial court brief—it has both waived that argument below and failed to preserve it for appeal. *See, e.g.*, *Bd. of Managers of Porter House Condo. v. Delshah 60 Ninth LLC*, 192 A.D.3d 415, 416 (1st Dep't 2021) (arguments not raised in trial court opening brief could not be considered below or on appeal); *Residential Bd. of Managers of Platinum v. 46th St. Dev., LLC*, 154 A.D.3d 422, 423 (1st Dep't 2017) (argument not raised until trial court reply brief "should not be considered"); *RSB Bedford Assocs., LLC v. Ricky's Williamsburg, Inc.*, 91 A.D.3d 16, 23 n.1 (1st Dep't 2011) (argument not raised in trial court brief is not properly before the court); *Feliz v. Fragosa*, 85 A.D.3d 417, 418 (1st Dep't 2011) (refusing to consider argument "improperly raise[d] for the first time on appeal"); *United Servs. Auto. Ass'n v. Kungel*, 72 A.D.3d 517, 518 (1st Dep't 2010) (argument raised for first time in reply brief waived); *Azzopardi v. Am. Blower Corp.*, 192 A.D.2d 453, 454 (1st Dep't 1993) ("[T]he court should never even have considered arguments making their initial appearance in reply papers."); *Whitler Contracting Corp. v. City of*

New York, 161 A.D.2d 484 (1st Dep't 1990) (finding "unpreserved for review the City's argument, raised for the first time on appeal"); *Cadlerock Joint Venture, L.P. v. John H. Fisher, P.C.*, 178 A.D.3d 1160, 1161 (3d Dep't 2019) ("[Appellants'] brief references facts outside of the record to advance arguments that were not placed before Supreme Court. Those arguments are unpreserved.").[37]

Thus, the City's new statutory cap argument is not properly before this Court and should be rejected on that basis alone. The City tacitly concedes this in its "Question Presented," which focuses entirely on whether the City must "subsidize[] other plans" (as explained above, it must) while making no mention of the subsidy amount or anything related to the statutory cap. City's Br. 4.

[37] The night before the trial court issued its ruling on the Petition, the City filed a one-and-a-half-page letter claiming, for the first time, that it had no duty to continue paying for Senior Care because that plan was somehow 25 times more expensive than the statutory cap. (R1970-71). The City offered no explanation as to how that could be or why it had never raised this issue before, and it cited no evidence or authority to support this inaccurate assertion. What appears to have happened is that after oral argument (during which the City conceded that Senior Care costs less than the statutory cap), the City saw the writing on the wall and sought to stave off defeat by creating a last-minute factual dispute. The trial court correctly rejected this meritless and procedurally improper tactic. *See Metropolitan Transp. Auth. v. 2 Broadway LLC*, 279 A.D.2d 315, 315 (1st Dep't 2001) (holding that it was error to consider an argument "improperly raised for the first time in a letter of counsel presented after the motion had been orally argued and submitted").

2. The City's statutory cap argument is meritless.

The City's unpreserved argument that the statutory cap has suddenly become $7.50 is also meritless, which is likely why the City did not press it below. Indeed, before even delving into the record, one can instantly recognize its absurdity.

The City is claiming that Section 12-126 requires it to pay up to $776 per person per month on health insurance coverage for active employees and retirees under age 65, but only $7.50 for elderly and disabled retirees, who have far more expensive healthcare needs. Although Medicare helps defray those costs, it does not cover a significant portion of expenses, which is why Medicare-eligible retirees need robust health insurance coverage that costs thousands of dollars a year.[38] The City has always paid for this coverage pursuant to Section 12-126. The City's contention that the statutory cap for these retirees is $7.50 per month—less than 1% of the cap for everyone else—sounds unbelievable because it is.

[38] Senior Care costs approximately $191 per month on an individual basis and $383 per month on a family basis.

The City claims that there are two statutory cap plans, one for Medicare-eligible retirees (the "HIP VIP Premier Medicare Plan" (R148)) and another for everyone else (the "HIP HMO Preferred Plan" (R113)). The former is known as the "HIP-VIP plan," while the latter is known as the "HIP-HMO plan." (*See, e.g.*, R1733). The City argues that the HIP-VIP plan sets the statutory cap for Medicare-eligible retirees while the HIP-HMO plan sets the cap for everyone else. That is not how Section 12-126 works.

As the City conceded below, the statutory cap is pegged to "the cost of *a particular plan*," specifically the "HIP-HMO" plan, on a "category basis." (NYSCEF No. 201 at 2-3). *See also New York 10-13 Ass'n v. City of New York*, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (explaining that "the H.I.P.-H.M.O. plan" is the universal "statutory yardstick"). Although there are two different categories of coverage within that plan (individual and family), there is and always has been one single health insurance plan that sets the statutory cap, not two. And the City has previously acknowledged that this plan is the HIP-HMO plan. (*See* NYSCEF No. 227 at 1 (stating that cost of the "H.I.P. H.M.O.

Preferred Plan . . . constitute[s] the maximum City cost established by the law")).

The City attempts to circumvent this problem by claiming that "Medicare-eligible" is actually a "category" for purposes of Section 12-126. City's Br. 35-36. That is incorrect. A "category" has always referred to types of coverage within the same plan, not to different plans.[39] And, as stated in the City's own documents, "category basis" refers to the two types of coverage that exist within the HIP-HMO plan: individual and family. (*See, e.g.*, R606 (stating that the City must pay for health insurance coverage up to "100% of the full cost of HIP-HMO on a category basis," and explaining that "category basis" refers to "individual or family")). Tellingly, the City cannot point to anything from the 55-year history of Section 12-126 stating that "Medicare-eligible" is a recognized "category" for purposes of the statute. That is because it is not.

The legislative history of Section 12-126 confirms that "Medicare-eligible" is not a recognized "category." The term "category basis" appears throughout the legislative record prior to the introduction of

[39] Section 12-126 originally referred to categories of coverage within the "H.I.P.-Blue Cross (21-day plan)." (R1321). In 1984, that plan was replaced by the HIP-HMO plan. (R1141).

Medicare in July 1966. For example, Resolution 292, which was passed in December 1965, used the term "category basis" no less than 13 times to refer to the City's healthcare payment obligations. (*See* R1343 (requiring the City to pay for health insurance coverage up to "the full cost of H.I.P.-Blue Cross (21-day plan) on a *category basis*"); R1344 (same); R1345 (same); R1346 (same); R1347 (same)). An earlier related resolution—Resolution Cal. No. 155, which was passed in February 1965—used the term in the exact same way. (*See* R1350 (requiring the "[a]ssumption by The City of New York of full payment for choice of health and hospital insurance, not to exceed 100 per cent of the full cost of HIP-Blue Cross (21-day plan) on a *category basis*")).

The City Council codified these resolutions, and copied their language verbatim, in Section 12-126. By doing so, the City Council clearly meant to import the same meaning of "category basis." *See People v. Duggins*, 3 N.Y.3d 522, 528 (2004) (holding that "where the same word or group of words is used in different statutes, if the acts are similar in intent and character the same meaning may be attached to them," and "when terms of art or peculiar phrases are used, it is supposed that the Legislature had in view the subject matter about which such terms or

phrases are commonly employed"); *Zuni Public Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 90-91 (2007) (explaining that an interpretation of a prior version of a regulatory definition remained the same where the legislature did not express the view that the new legislation was intended to require a change in the definition). Indeed, nothing in the legislative history suggests that the City Council meant "category basis" to mean something different in Section 12-126 than in the resolutions it codified. And because those resolutions were passed before Medicare even existed, "Medicare-eligible" could not possibly have constituted a recognized "category basis."

There are at least three additional reasons why the City's unpreserved statutory cap argument fails.

First, as the City concedes, it has always paid for Senior Care, which has historically cost more than the HIP-VIP plan. City's Br. 40. Thus, by paying for Senior Care, which is costlier than the HIP-VIP plan, the City has implicitly conceded that the HIP-VIP plan does not set the statutory cap, since the cap is the maximum the City is allowed to pay for health insurance coverage. *See* N.Y.C. Admin. Code § 12-126(b)(1) (stating that the City's payment for the "cost of health insurance

coverage" is "not to exceed" the cost of the HIP-HMO plan); *see also* NYSCEF No. 227 at 1 (City acknowledgment that the HIP-HMO cap "constitute[s] the maximum" cost permitted "by the law").

Second, the HIP-VIP plan cannot set the statutory cap because it will be phased out of existence after the City's implementation of the new Medicare Advantage plan. As part of the City's effort to force retirees into a Medicare Advantage plan, it announced that it would no longer be offering the HIP-VIP plan—or any other HIP plan—to new Medicare-eligible enrollees, and that HIP-VIP's few existing members would be automatically transferred into the City's new Medicare Advantage plan unless they affirmatively opted out.[40] The statutory cap cannot possibly be pegged to a closed plan that will soon cease to exist.

Lastly, even if the HIP-VIP plan were to set the statutory cap (which it does not), there is no evidence that its cost has suddenly dropped from $182 per person per month to $7.50, as the City claims.[41]

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[40] *See* NYSCEF No. 208 at p.16; *Frequently Asked Questions (FAQs) About the NYC Medicare Advantage Plus Plan*, https://www1.nyc.gov/assets/olr/downloads/pdf/health/ma-faqs-11-19-21.pdf at 1, 3.

[41] Although the City claims that the cost of the HIP-VIP plan dropped overnight from $182 per person per month to $7.50, it cannot point to any evidence in the record to support that claim. The City's brief is riddled with similarly unsupported factual assertions. *See, e.g.*, City's Br. 37 n.14 (describing supposed features of the plan that

City's Br. 14, 23, 35. The cost of the HIP-VIP plan, like every other health insurance plan offered by the City, has steadily risen every single year. In 2017, the per-person-per-month cost to the City was $161, which increased to $165 in 2018, $171 in 2019, and $175 in 2020 (of course, these costs were all absorbed by the City pursuant to Section 12-126). In 2021, when Petitioners filed the present suit, the cost was approximately $182, only slightly below the $191 cost of Senior Care (which the City also paid in full pursuant to Section 12-126). Yet somehow, according to the City, the cost of the HIP-VIP plan has suddenly plummeted to $7.50 while the cost of other plans have continued to increase. Apparently EmblemHealth, which administers the HIP-VIP plan, forgot that "healthcare costs" were supposed to be "rising" to "unsustainable" and "potentially disastrous" levels. City's Br. 3, 16.[42]

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set the original statutory cap, the HIP-Blue Cross (21-day) plan). The City's attempt to rest their appeal on new and unsupported "facts" should be rejected.

[42] The City's claim that EmblemHealth dropped the price of the HIP-VIP plan from $182 to $7.50 to "compete with the premium-free MAPP" does not withstand scrutiny. City's Br. 40 n.18. The HIP-VIP plan has always competed with multiple premium-free plans. And other plans—including Senior Care, which is also administered by EmblemHealth—have continued to increase in price despite the prospect of a premium-free MAPP. The City's claim is also self-defeating. If the HIP-VIP plan set the statutory cap, it would not need to drastically reduce its price in order to compete, since Section 12-126 requires the City to pay the full cost of the statutory cap plan.

The City would have this Court deny healthcare benefits to hundreds of thousands of senior citizens and disabled first responders based on the unsupported, unpreserved, and improbable claim that the cost of the HIP-VIP plan—which does not even set the statutory cap—has magically decreased by more than 95%. The Court should reject this desperate and deeply flawed litigation tactic.[43]

CONCLUSION

For the reasons set forth above, the Court should affirm the trial court order requiring the City to continue subsidizing health insurance for Medicare-eligible retirees regardless of which plan they select.

Dated: September 7, 2022
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[43] There is no evidence in the record to suggest that the cost of the HIP-VIP plan is $7.50. Thus, even if the City had preserved its statutory cap argument (which it has not), and even if the HIP-VIP plan set the statutory cap (which it does not), this Court would have to remand the case to the trial court to determine the actual, legitimate cost of that plan.

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