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

ROBERT BENTKOWSKI, KAREN ENGEL, MICHELLE FEINMAN, NANCY LOSINNO, JOHN MIHOVICS, KAREN MILLER, ERICA RHINE, ELLEN RIESER, and BEVERLY ZIMMERMAN, on behalf of themselves and all others similarly situated, and THE NEW YORK CITY ORGANIZATION OF PUBLIC SERVICE RETIREES, INC.,

Petitioners-Plaintiffs,

v.

THE CITY OF NEW YORK; ERIC ADAMS, Mayor of the City of New York; THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS; RENEE CAMPION, Commissioner of the Office of Labor Relations; THE NEW YORK CITY DEPARTMENT OF EDUCATION (a/k/a THE BOARD OF EDUCATION OF THE CITY SCHOOL DISTRICT OF THE CITY OF NEW YORK); and DAVID C. BANKS, Chancellor of the New York City Department of Education,

Respondents-Defendants.

Index No.: 154962/2023

(Hon. Lyle E. Frank)

PETITIONERS-PLAINTIFFS' MEMORANDUM OF LAW IN FURTHER SUPPORT OF THEIR MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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The City advances meritless arguments for why it should be allowed to strip Retirees of their longstanding Medicare benefits and force them into an inferior Medicare Advantage plan. As explained below, this Court should reject these arguments and grant Petitioners' preliminary injunction motion.

I. THE CRITICAL FACTS ARE UNDISPUTED

The City does not, and cannot, dispute the fundamental ways in which the Aetna MAP is worse than Medicare-plus-supplemental insurance. The following facts, among others, are undisputed.

- **Limited network of medical providers**: Unlike Medicare-plus-supplemental insurance, which allows Retirees to see any medical provider they like without any network restrictions, the Aetna MAP will have a limited network of providers. Contrary to Aetna's flawed prediction regarding the number of medical providers that will likely accept the plan based on past "indicat[ions]" from those providers (City Br. at 2), doctors, hospitals, and continuing care facilities are consistently telling Retirees they will not accept the plan, and many others are saying they do not yet know if they will. Pizzitola Aff., Ex. 1.
- **Prior authorization**: Retirees will be subject to Aetna's prior authorization requirements, meaning Retirees will be denied coverage for prescribed medical services and medications if Aetna does not believe they are necessary. Although the list of medical services and medications that are subject to prior authorization is (for the first two years) more limited than some other Medicare Advantage plans, that list is still expansive and covers many important and common services and medications. *See* Omdahl Aff. p.6 ¶¶ 9-18. There is overwhelming data—unrebutted by the City—confirming that prior authorization routinely causes life-threatening denials of and delays in medical care, and that Aetna has the highest

prior authorization denial rate in the industry (12%, which is twice the national average). Aetna touts the fact that, on average in any given year, "only" 80% of its MAP enrollees undergo the prior authorization process and that "only" 10% of its MAP enrollees are denied care ordered by their doctor. Moffitt Aff. ¶¶ 16-17. Those are not the reassuring statistics Aetna thinks they are. Although the nightmarish examples of Aetna denying coverage are too extensive to document here, the story of Orrana Cunningham is instructive. She had cancer, which her doctors wanted to treat with a targeted form of radiation. Aetna unjustifiably denied coverage, and she died a year later after not receiving the treatment she needed. Although Aetna was recently forced to pay a $25.5 million judgment to Mrs. Cunningham's family, no amount of money can undo the harm it caused.[1]

- **Retirees will have to pay for their own medical care**: There are various scenarios under the Aetna MAP in which Retirees will have to pay the full cost of their medical care, which could be tens of thousands of dollars. These scenarios include when Aetna retrospectively determines that previously performed medical care was not necessary, Gardener Aff., Ex. D at Chapter 3, § 2.3, and when a medical provider chooses to bill the Retiree instead of Aetna, Gardener Aff., Ex. K.[2] Aetna will not reimburse for services it deems unnecessary.

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[1] *See* Wayne Drash, *Jury delivers $25.5 million 'statement' to Aetna to change its ways*, CNN, Nov. 10, 2018, https://www.cnn.com/2018/11/10/health/aetna-verdict-oklahoma-orrana-cunningham/index.html.

[2] Medical providers will likely bill patients instead of Aetna because Aetna is notorious for failing to pay providers what they are owed and for making the payment process difficult. *See, e.g.*, *Da Silva Plastic and Reconstructive Surgery, P.C. v. Aetna*, Index No. 614921/2023 (Sup. Ct. Suffolk Cty.) (alleging that Aetna failed to timely pay medical providers for services); *Surgical Specialists of Greater New York LLP v. Aetna Health Inc., Aetna, Inc., and Aetna Life Ins. Co.*, Index No. 654667/2022 (Sup Ct. N.Y. Cty.) . (alleging improper remittance of payments); *Island Eye Surgicenter v. Aetna Health Inc.*, Index No. 609649/2022 (Sup. Ct. Nassau Cty.) (alleging that Aetna repeatedly denied payment for services); *Atlantic Short Surgical Assoc. v. Aetna Health and*

Aetna might eventually reimburse a Retiree who is billed directly by her provider, but most Retirees do not have the cash on hand to cover such costs and wait weeks for possible reimbursement.

- **Increased co-pays and drug costs**: Retirees will all be charged co-pays for a variety of medical services (which is not the case under their existing Medicare-plus-supplemental insurance), and many will face various increases in prescription drug premiums and drug costs. These Retirees—most of whom, it is undisputed, subsist on small pensions—generally cannot afford any unexpected increases in healthcare costs, as their ongoing co-pay class action has demonstrated.

Thus, despite the City's efforts to downplay the significant risks associated with the Aetna MAP, there is no question that automatically enrolling Retirees in that plan will imperil the health and financial stability of countless elderly and disabled individuals.

II. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR PROMISSORY ESTOPPEL CLAIM

The City does not, and cannot, dispute the three facts that are relevant to Petitioners' promissory estoppel claim.

First, the City does not dispute that, for the past half-century, it has repeatedly told all employees and retirees in countless documents, "**When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare," with the City's "Health Benefits Program provid[ing] a second level of benefits intended to**

Life Ins. Co., Index No. 711464/2022 (Sup. Ct. Queens Cty.) (alleging that Aetna's payment for emergency services rendered by out-of-network providers was late and insufficient).

fill certain gaps in Medicare coverage."[3] Pizzitola Aff., Exs. 3 at 12, 4 at 39, 5 at 46, 6 at 47, 7 at 49, 8 at 51, 9 at 51, 10 at 14, 11 at 14, 12 at 14, 13 at 14, 14 at 14, 15 at 14, 18 at 3. Nor does the City dispute that countless City officials—including the Deputy Mayor for Health and Human Services and the heads of the Employment, Personnel, and Human Resources Administration Departments—verbally promised employees for decades that when they and their dependents became Medicare-eligible, they would be entitled to City-funded Medicare-plus-supplemental insurance. Pizzitola Aff. ¶ 14; Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52-57); Barrios-Paoli Aff. ¶¶ 4-7, 27-28. That clear promise of future health benefits was described by a top City official as "*an essential recruiting and retention tool*." Barrios-Paoli Aff. ¶ 27 (emphasis added).

Second, the City does not dispute that Retirees relied on these statements by the City as a promise of Medicare plus supplemental insurance when they became Medicare-eligible.

Third, the City does not dispute that Retirees made important and irreversible employment, medical, financial, and residence decisions throughout their lives in reliance on this promise, and that they would have made very different decisions had they known the City would not keep its promise.

Unable to contest these dispositive facts, which satisfy the three elements of promissory estoppel, the City resorts to making meritless arguments on the law. These arguments are refuted below.

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[3] Petitioners' opening brief mistakenly included a slightly different formulation of this promise in the SPDs from the 1980s. The brief stated that the promise made in SPDs from the 1980s began, "At age 65+ (and thereafter) . . . ." Petrs.' Op. Br. at 25. In fact, the promise made in SPDs from the 1980s began just like the promise made in subsequent decades: "When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled . . . ." Pizzitola Aff., Ex. 3 at 12.

A. The City's promise was clear and unambiguous.

The City contends that Petitioners "fail to identify a clear and unambiguous promise." City Br. at 4. The record is replete with clear and unambiguous statements by the City that when Retirees became Medicare-eligible, they would be provided Medicare plus supplemental insurance. Approximately 350 affiants testified to this promise being made in verbal communications and in writing. *See* Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52-57). Lilliam Barrios-Paoli, a former Deputy Mayor and Commissioner who led multiple City agencies across four administrations, testified that, for over 50 years, City officials promised prospective, active, and retired employees that "when a worker retired and became Medicare-eligible, Medicare would become the primary insurer and the City's Health Benefits program would supplement Medicare." Barrios-Paoli Aff. ¶ 24. That is as clear and unambiguous as it gets.

Hundreds of Retirees testified to this exact same unambiguous promise. Although their affidavits are available at NYSCEF Nos. 29-37 (Petitioner affidavits) and 52-57 (other Retiree affidavits), we offer four representative examples of that testimony here:

- Petitioner Karen Miller testified that "in verbal communications by the City throughout my employment," "the City repeatedly promised that when I retired and became eligible for Medicare, the City would provide me with . . . a premium free Medicare Supplemental health insurance plan and reimburse me for Medicare Part B premiums." Miller Aff. ¶ 3.
- Retiree Jeannette Knowles testified that in countless "verbal" communications "[d]uring my employment with the City and during my retirement, the City repeatedly promised that when I retired and became eligible for Medicare, the City would pay for my Medicare Part B premium plus my choice of a Medicare Supplemental plan." NYSCEF No. 52 at 35.

- Retiree Denise Abdale testified that "every single year" she was "repeatedly promised" by City pension officers "that when I retired and became eligible for Medicare, the City would pay for my Medicare Part B premiums plus my choice of a Medicare Supplemental plan." NYSCEF No. 57 at 2.
- And Retiree James Carrano testified that "[a]t [NYPD] orientation we were informed of our benefit package and were told we would have free lifetime medical benefits in the form of Traditional Medicare plus a Medicare Supplement Plan." NYSCEF No. 57 at 17.

Hundreds of Retirees—representing the shared experience of hundreds of thousands of their peers—similarly described this clear promise that was made to them and others. Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52-57). The City does not, and cannot, rebut this sworn testimony. Indeed, the City does not offer a single affidavit or other piece of evidence refuting the testimony that City officials promised Retirees they would be provided Medicare plus supplemental insurance when they became Medicare-eligible.

Moreover, the City informed all prospective, active, and retired employees in writing for nearly 60 years in a vast array of documents that when they "bec[a]me[] Medicare-eligible," they would be entitled to Medicare as their "first level of health benefits" plus "supplemental" insurance to fill in the "gaps" in Medicare coverage. *See* Petrs.' Op. Br. at 24-30. There is nothing unclear or ambiguous about that.

The City's reliance on *Randall's Island Aquatic Leisure, LLC v. City of New York*, 92 A.D.3d 463 (1st Dep't 2012), is misplaced. City Br. at 4. The alleged promise in that case was "that 'possible loans' were being 'considered.'" 92 A.D.3d at 464. That is obviously not a clear and unambiguous promise, and it bears no resemblance to the promise at issue in this case. The other cases cited by the City involving unclear promises are similarly distinguishable.

B. The City's promise was forward-looking.

The City contends that its promise of Medicare plus supplemental insurance was not "forward-looking." City Br. at 6, 7, 9-10. That is demonstrably false. The written formulation of the promise dating back to at least the 1980s (and likely the mid-1970s) stated that, if employees devoted their careers to the City, the City would reward them and their dependents with Medicare plus supplemental insurance "**when [they] or one of [their] dependents becomes eligible for Medicare**." Pizzitola Aff., Ex. 3 at 12. The formulation was not "if you or one of your dependents is eligible for Medicare *now*," or "when you or one of your dependents becomes eligible for Medicare *this year*." It was "*when you or one of your dependents becomes eligible for Medicare*" — whenever in the future that may. Any reasonable person would construe—and Retirees all did construe—that to be a forward-looking statement about the healthcare they would have when they became Medicare-eligible. *See In re Lois/USA, Inc.*, 264 B.R. 69, 112 n.121 (Bankr. S.D.N.Y. 2001) (noting reasonable person standard). If one were to hear throughout their career and their retirement that "when you or one of your dependents becomes eligible for Medicare, your first level of health benefits is provided by Medicare," any reasonable person would conclude that when they or one of their dependents became eligible for Medicare, their first level of health benefits would be provided by Medicare, and that they could not be forced into a Medicare Advantage plan (where the first level of health benefits is <u>not</u> provided by Medicare).

To the extent there was any confusion—and there was not—verbal communications with City officials over the years confirmed that the promise was forward-looking, and that Retirees would be entitled to Medicare plus supplemental insurance whenever in the future they became eligible for such insurance. Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52-57). The City simply ignores

the hundreds of Retirees, former City officials, and experts that testify to this clear forward-looking promise. *Id*.

The promise made by the City was no less forward-looking than the promises at issue in various other cases in which government defendants were estopped from denying promised benefits. *See, e.g.*, *Agress v. Clarkstown Cent. Sch. Dist.*, 69 A.D.3d 769, 770 (2d Dep't 2010) (promise that "[o]nce [plaintiff] reached the age of 55, the School District would then be responsible for payment of 50% of the premiums"); *Vassenelli v. City of Syracuse*, 138 A.D.3d 1471, 1475 (4th Dep't 2016) (plaintiff did not even rely on any explicit promise, but rather "on the city defendants' payment for services and medications prior to August 2009"); *Branca v. Bd. of Educ., Sachem Cent. Sch. Dist. at Holbrook*, 239 A.D.2d 494, 495 (2d Dep't 1997) (promise that employees "would nonetheless receive the increases in compensation and the fringe benefits provided for in the collective bargaining agreement"); *Hohenberger v. Smithtown Cent. Sch. Dist.*, 58 Misc. 3d 6, 9 (2d Dep't App. Term. 2017) ("verbal assurances made by an individual employed in [the government's] personnel office that [plaintiff] would be paid for her unused accumulated sick leave"); *Gendalia v. Gioffre*, 191 A.D.2d 476, 477 (2d Dep't 1993) (promise "by the Town Supervisor that [plaintiffs] could accumulate unused time and defer vacations or receive compensation at a later date"); *Garrigan v. Inc. Vill. of Malverne*, 12 A.D.3d 400, 401 (2d Dep't 2004) (promises of "payment for accumulated but unused benefits upon retirement"); *Brennan v. New York City Hous. Auth.*, 72 A.D.2d 410, 411 (1st Dep't 1980) (promise made to police officers by their superiors "that their then contemplated move [out of state] was lawful").

Because the City's promise was unquestionably forward-looking and not merely a statement of present facts, the cases cited by the City in support of its straw-man argument that it cannot be estopped by current practice are irrelevant. *See* City Br. at 7-9.

C. The City's promise is not negated by other statements.

The City argues that language in certain documents "belies" the clear promise it made of Medicare plus supplemental insurance. City Br. at 5. Specifically, the City points to language from two SPDs. The cited language from these SPDs in no way undermines the City's promise.

First, the City points to an SPD from 1994, which contains the following disclaimer at the top of Section Four: "This Summary Program Description is for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws." *Id*. (quoting Pizzitola Aff., Ex. 5 at 6). Importantly, however, this disclaimer is specific to the section of the SPD that summarizes the particular health insurance plans available at that time. The section heading and full disclaimer read as follows:

SECTION FOUR

SUMMARY DESCRIPTION OF HEALTH PLANS

> Summaries of the benefits of the available health plans appear on the pages that follow. They are presented so that it is easy to compare the benefits of the different plans. This Summary Program Description is for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

Id. Thus, the disclaimer notifies readers that the specific mix of insurance plans offered by the City and the benefits associated with those plans, all of which are summarized in Section Four, are governed by contracts between the City and insurance companies and are subject to applicable laws. Petitioners do not dispute that the particular plans offered by the Health Benefits Program can evolve over time, are governed by contracts between the City and insurance companies, and are subject to applicable laws (including Section 12-126). But those unremarkable facts do not mean that the City can refuse to provide Retirees promised access to Medicare plus supplemental insurance. That promise appears in a completely separate section of the SPD (Section Five), which

is labeled "General Information," *id*. at 39, and contains information about more permanent features of the Health Benefits Program. *See id*. at 46 (stating the promise).

The City also points to language from a 1983 SPD, which states, "In these times of rapidly rising health care costs, any unnecessary use of health insurance adds further to costs and could limit the possibility of future benefits." City Br. at 5 (quoting Pizzitola Aff., Ex. 3 at 3). This public advisement to use health benefits wisely hardly negates the City's clear promise of Medicare plus supplemental insurance.

Lastly, even if the language cited in these two SPDs somehow qualified the City's promise in those documents (which it does not), it could not qualify the promise made in all of the other City documents and in the countless verbal communications.

D. Estoppel of government entities is unquestionably permitted and common.

Courts routinely estop governmental entities from denying promised benefits in circumstances far less compelling than those here. *See, e.g., Emporium Mgmt. Corp. v. City of New York*, 121 A.D.3d 981, 983 (2d Dep't 2014) (stating that "we have not hesitated" to estop governmental entities when circumstances require it, and granting plaintiff hearing to compel City's compliance with tax-related promises).

For example, in *Agress*, the plaintiff was allowed to pursue her promissory estoppel claim compelling the government to provide her with continuing health insurance benefits post-employment because a benefits officer mistakenly told her she was entitled to them. 69 A.D.3d at 771.

In *Allen v. Board of Educucation of Union Free School District No. 20*, 168 A.D.2d 403 (2d Dep't 1990), the plaintiffs successfully asserted a promissory estoppel claim against the

government for continued health insurance premium contributions based on verbal representations that they were entitled to such contributions. 168 A.D.2d at 404.

In *Zamostina v. New York City Employees' Retirement System*, 189 A.D.3d 1256 (2d Dep't 2020), the City was estopped from changing retirees' pension benefits and ordered to reimburse previously collected amounts because the retirees were "the victim of bureaucratic confusion and deficiencies." 189 A.D.3d at 1259.

In *Vassenelli v. City of Syracuse*, 138 A.D.3d 1471, 1475 (4th Dep't 2016), the plaintiff successfully alleged promissory estoppel against the City of Syracuse based solely "on his reliance on the city defendants' payment for [medical] services and medications prior to August 2009." There was not even an explicit promise—just past practice. 138 A.D.3d at 1475.

In *Hohenberger*, the plaintiff's testimony "that she relied on express verbal assurances made by an individual employed in [the government's] personnel office that she would be paid for her unused accumulated sick leave . . . was sufficient to warrant an award to plaintiff of damages under a theory of promissory estoppel." 58 Misc. 3d at 9.

In *Gendalia*, plaintiffs successfully alleged a promissory estoppel claim against the government to compel payment of accumulated sick leave and vacation time because plaintiffs had been "assured by the Town Supervisor that they could accumulate unused time and defer vacations or receive compensation at a later date." 191 A.D.2d at 477.

In *Brennan v. New York City Hous. Auth.*, 72 A.D.2d 410 (1st Dep't 1980), the City was estopped from enforcing residency requirements for police officers because at the time of their hiring, they "receiv[ed] assurances from superior officers that their then contemplated move [out of state] was lawful." 72 A.D.2d at 411.

There are myriad other Appellate Division cases like these. *See, e.g., Branca*, 239 A.D.2d at 495 (affirming viability of promissory estoppel claim compelling government to provide employees benefits they were promised); *Garrigan*, 12 A.D.3d at 401 (affirming viability of estoppel claim against government requiring it to provide promised benefits); *Colton v. Sperry Assocs. Fed. Credit Union*, 50 Misc. 3d 129(A) (2d Dep't App. Term. 2015) (estopping government employer from denying benefits plaintiff "had been told by a member of defendant's human resources department that he would [receive]"); *Padilla v. Dep't of Educ. of City of New York*, 90 A.D.3d 458, 459 (1st Dep't 2011) (estopping City from challenging plaintiff's notice of claim based on the reliance it induced); *Landmark Colony at Oyster Bay v. Bd. of Sup'rs*, 113 A.D.2d 741, 744 (2d Dep't 1985) (estopping County of Nassau and its Planning Commission from imposing penalty in light of their prior approval of plaintiff's real estate project).[4]

These are just a sample of the large body of caselaw involving estoppel against the government in circumstances far more mundane than those here. What makes this case different—and even *more* deserving of estoppel—is that: (1) the promise at issue was made in countless documents and verbal communications for over half a century, and not just in a stray conversation with a random administrator; (2) hundreds of affiants—including high-ranking City officials who made the promise—have provided unrebutted testimony confirming this promise; (3) the promise

[4] Though not a government estoppel case, *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001), is instructive because of its factual similarities to the present case. In *Devlin*, a Second Circuit panel that included now-Justice Sotomayor ruled in favor of retirees on their promissory estoppel claim due to the promise of lifetime insurance benefits made in an SPD. Because it was an ERISA case, the claim required an extra showing of "extraordinary circumstances." The court held that such circumstances existed because, as in the present case, "a trier of fact could reasonably conclude that Empire intentionally promised lifetime life insurance benefits to lure (and retain) employees away from other firms paying higher salaries and then denied those benefits after the employees were of an age where they could neither make up the salary difference or obtain alternative benefits at a reasonable cost." 274 F.3d at 86-87.

represented the official, longstanding position of the City itself, as opposed to the statement of a mistaken employee on a single occasion[5]; (4) the promise was consistent with, and compelled by, local and state statutes, as opposed to being contrary to the law; (5) the promise concerns important healthcare benefits on which the lives of hundreds of thousands of senior citizens and disabled first responders depend; and (6) the promise has been continuously honored for nearly 60 years.

The City fails to distinguish the mountain of caselaw supporting Petitioners' promissory estoppel claim. For instance, the City claims that estoppel was warranted in *Agress* because the defendant school district advised the plaintiff that she would receive various benefits and "the school district in fact incorrectly provided those benefits for several years." City Br. at 15. But that is exactly what happened here: Retirees were told by the City (verbally and in writing) that they would have access to Medicare plus supplemental insurance, and they were provided those benefits for 57 years. Thus, even by the City's own logic, estoppel is warranted in this case. *Agress* is controlling and dispositive.

Unable to escape the controlling, on-point caselaw and undisputed facts that compel estoppel here, the City resorts to misrepresenting the law. It claims that "estoppel claims against government entities, including Respondents, are barred under New York law." City Br. at 11. That is simply wrong, as the cases above demonstrate.

Although courts historically resisted applying estoppel to the government, "in recent times the judiciary has retreated from this rigid standard and currently employs a flexible medium in examining the specific facts of each case." *Brennan*, 72 A.D.2d at 412. "[E]stoppel is applicable

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[5] *See LaPorto v. Vill. of Philmont*, 39 N.Y.2d 7, 12 (1976) (estopping municipality because of "inaction and passivity on the part of the village itself as a corporate entity" for "more than 80 years," and distinguishing that from efforts to estop "a municipality from disclaiming the unauthorized or unlawful acts of its officers").

to all units of local government" and may be applied "to promote the ends of justice" and prevent any "manifest injustice that has occurred or will occur." *Id*. A governmental entity may be estopped, even when "acting in a governmental capacity," when it "acted wrongfully, negligently or induced" detrimental reliance through its promises or actions. *New York City Hous. Auth. v. Oakman*, 184 A.D.3d 431, 433 (1st Dep't 2020) (rejecting estoppel claim in that case because the three elements were not satisfied). Indeed, as the Court of Appeals has held, the City "should be estopped" when its conduct "induc[es] reliance by a party who is entitled to rely and who changes his position to his detriment or prejudice." *Bender v. New York City Health & Hosps. Corp.*, 38 N.Y.2d 662, 668 (1976).

The closest thing to the City's purported "rule barring estoppel claims against government entities," City Br. at 13, is when a government agent mistakenly promises something that is statutorily forbidden. Courts have generally declined to estop the government in that situation because doing so would "prevent it from discharging its statutory duties." *N.Y. State Med. Transporters Ass'n, Inc. v. Perales*, 77 N.Y.2d 126, 130 (1990). That is the fact pattern in virtually all of the cases relied on by the City. *See, e.g.*, *id*. at 128, 130 (refusing to estop government from requiring prior agency approval because such approval was "a statutory prerequisite"); *Brown v. New York State Teachers' Ret. Sys.*, 107 A.D.2d 103 (3d Dep't 1985) (refusing to apply estoppel because statute prohibited pension benefits that pension fund officer erroneously advised plaintiff he would receive); *Leisten v. McCall*, 285 A.D.2d 897, 899 (3d Dep't 2001) (refusing to estop government because it "was required by law" to deny petitioner's application for retirement benefits); *Westmorland v. New York State & Loc. Ret. Sys.*, 129 A.D.3d 1402 (3d Dep't 2015) (refusing to estop government because petitioner was given erroneous advice regarding her rights under the Retirement and Social Security Law); *Caldwell v. New York City Transit Auth.*, 39 Misc.

3d 1242(A) (Sup. Ct. N.Y. Cty. 2013) (refusing to estop government because plaintiff failed to comply with applicable law); *Keep Food Legal v. New York City Dept. of Health and Mental Hygiene*, 2014 WL 640240 (Sup. Ct. N.Y. Cty. Feb. 10, 2014) (same).[6]

That is not the fact pattern here. The City does not, and cannot, identify any statute requiring the City to deny Retirees access to Medicare plus supplemental insurance (in fact, as explained in the following section, the law affirmatively requires the City to provide this insurance). The City simply decided—without any statutory requirement—to save money on the backs of Retirees by stripping them of their City-funded health insurance. It is well-settled that "a governmental entity may be estopped from taking action where," as here, "it is acting within the realm of discretion." *Drs. Council v. New York City Employees' Ret. Sys.*, 127 A.D.2d 380, 393 (1st Dep't 1987), *rev'd on other grounds*, 71 N.Y.2d 669 (1988).

Yet even if Retirees *had* been given erroneous advice by a misinformed government agent and that advice *had* contradicted some governing statute (neither of which happened), the City would *still* be estopped from denying Retires access to Medicare plus supplemental insurance. That is because, although "[a]s a general rule, estoppel may not be invoked against a governmental body to prevent it from performing its statutory duty . . . [, a]n exception to the general rule is where a governmental subdivision acts or comports itself wrongfully or negligently, inducing reliance by a party who is entitled to rely and who changes his position to his detriment or prejudice," or "where the plaintiff has been the victim of bureaucratic confusion and deficiencies."

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[6] Oddly, the City also cites *Barbera v. New York City Emps. Ret. Sys.*, 211 A.D.2d 406 (1st Dep't 1995), City Br. at 12, even though the Court in that case ruled in *favor* of the retiree petitioner and held that the City's "10 year lag in asserting an unprecedented position to recoup past disability payments from a pensioner who relied upon 20 years of prior consistent, contrary City policy was both arbitrary and capricious." 211 A.D.2d at 408.

Agress, 69 A.D.3d at 771; *see also E.F.S. Ventures Corp. v. Foster*, 71 N.Y.2d 359, 369 (1988) (explaining that although "estoppel may not be invoked against a governmental agency to prevent it from discharging its statutory duties[,] . . . exceptions to the general rule may be warranted in unusual factual situations to prevent injustice").

Through its written and verbal promises of Medicare plus supplemental insurance spanning nearly 60 years, the City has "induc[ed] reliance" by Retirees who were "entitled to rely and who change[d their] position to [their] detriment or prejudice"; they were also "the victim of bureaucratic confusion and deficiencies." *Agress*, 69 A.D.3d at 771. Moreover, given the potentially life-or-death consequences to thousands of elderly and disabled individuals, this case presents an "unusual factual situation" where estoppel is warranted "to prevent injustice." *E.F.S. Ventures Corp.*, 71 N.Y.2d at 369. Thus, even if estoppel somehow "prevent[ed the City] from discharging its statutory duties," which it clearly would not, such relief would *still* be required here. *Id*.

In conclusion, the City is essentially telling Retirees they never should have trusted the fundamental healthcare promise it made to them throughout their careers and retirements. That is deeply disturbing, and it erodes public trust in government. As the Supreme Court put it: "To say to these [Retirees], 'The joke is on you. You shouldn't have trusted us,' is hardly worthy of our great government." *Heckler v. Cmty. Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 60 n.13 (1984). This Court need not, and should not, sanction this injustice.

E. Promissory estoppel is not precluded by Retirees' expired collective bargaining agreements.

Non-party MLC argues that Petitioners' promissory estoppel claim is precluded by the existence of collective bargaining agreements. MLC Br. at 10-11. That argument does not merit extended discussion. The City (the actual party here) does not make the argument, nor does it

adopt it by reference. Moreover, the argument is easily refuted, which is likely why the City declined to make, or even adopt, it.

First, the promise underlying Petitioners' promissory estoppel claim is independent of any statement made in any collective bargaining agreement. In other words, the claim is not duplicative of a potential breach of contract claim. *See, e.g.*, *Forman v. Guardian Life Ins. Co. of Am.*, 76 A.D.3d 886, 888 (1st Dep't 2010) (affirming viability of promissory estoppel claim where promise was independent of parties' contract); *Celle v. Barclays Bank P.L.C.*, 48 A.D.3d 301, 303 (1st Dep't 2008) (explaining that promissory estoppel claim is not precluded by contract where underlying promise is "independent of the agreement"); *Soldiers', Sailors', Marines' & Airmen's Club, Inc. v. Carlton Regency Corp.*, 30 Misc. 3d 352, 364 (Sup. Ct. N.Y. Cty. 2010) (sustaining promissory estoppel claim because of "the allegation of promises independent from the various agreements"); *Hartshorne v. Roman Cath. Diocese of Albany*, 68 Misc. 3d 849, 851 (Sup. Ct. Schenectady Cty. 2020), *aff'd*, 200 A.D.3d 1427 (3d Dep't 2021) (permitting promissory estoppel claim to the extent "defendants made promises independent from the alleged promises made to the plaintiffs that are the subject of the breach of contract cause of action"); *Picini v. Chase Home Fin. LLC*, 854 F. Supp. 2d 266, 275 (E.D.N.Y. 2012) (sustaining promissory estoppel claim because it was "independent from Plaintiffs' TPP contract claim").

Second, the MLC cannot identify a single collective bargaining agreement that addresses any specific healthcare benefits to which Retirees are entitled. Where, as here, "the contract does not cover the dispute in issue, a plaintiff may proceed upon a theory of quasi-contract," such as promissory estoppel. *Hochman v. LaRea*, 14 A.D.3d 653, 655 (2d Dep't 2005); *see also Kramer v. Greene*, 142 A.D.3d 438, 441–42 (1st Dep't 2016) ("where there is a bona fide dispute as to the . . . application of a contract in the dispute in issue, a plaintiff may proceed upon a theory of quasi

contract"); *Mancuso v. L'Oreal USA, Inc.*, 2021 WL 1240328, at *4 (S.D.N.Y. Apr. 2, 2021) (explaining that promissory estoppel claim is not precluded "where the contract does not cover the dispute in issue" (quoting *Am. Tel. & Util. Consultants v. Beth Isr. Med. Ctr.*, 763 N.Y.S.2d 466, 466 (1st Dep't 2003)).[7]

Third, the collective bargaining agreements that previously governed Retirees have long since expired and, "[a]s a general rule, contractual rights and obligations do not survive beyond the termination of a collective bargaining agreement." *Kolbe v. Tibbetts*, 22 N.Y.3d 344, 353 (2013). Where, as here, the contract at issue no longer governs, there can be no bar to a promissory estoppel claim. *Forman*, 76 A.D.3d at 888 (affirming viability of promissory estoppel claim where contract had expired); *Int's Elecs., Inc. v. Media Syndication Glob., Inc.*, 2002 WL 1897661, at *1 (S.D.N.Y. Aug. 17, 2002) (holding that plaintiff could recover on theory of promissory estoppel if "the written contract expired"); *NCC Sunday Inserts, Inc. v. World Color Press, Inc.*, 759 F. Supp. 1004, 1011 (S.D.N.Y. 1991) ("An action for promissory estoppel generally lies when . . . the contract cannot be enforced for one reason or another.").[8]

Tellingly, collective bargaining agreements existed in all of the promissory estoppel cases cited above involving benefits promised to active or retired government employees. In none of

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[7] The MLC incorrectly suggests that a contract-based argument advanced by a different group of Retirees in the first MAP litigation is relevant here. However, the issues and arguments were different, the petitioners were different, and the Court did not find that Retirees had a continuing contractual right to anything.

[8] The MLC references agreements between it and the City in 1992 and 2018. However, neither agreement precludes the City's promise of Medicare plus supplemental insurance. In addition, the promise predates those agreements. Further, it is black-letter law that unions—and, by extension, the MLC—do not represent retirees. *See, e.g., Kolbe*, 22 N.Y.3d at 354 ("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").

those cases did the existence of such agreements undermine the viability of the promissory estoppel claims. Nor does it here.

III. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR CLAIM THAT SECTION 12-126 REQUIRES THE CITY TO OFFER MEDICARE PLUS SUPPLEMENTAL INSURANCE

Section 12-126 not only permits the City to offer Retirees Medicare plus supplemental insurance, it affirmatively requires it. Distorting the statutory text and legislative history, the City contends that Section 12-126 permits it to offer Medicare Advantage only. City Br. at 36-40. The City's interpretation of Section 12-126 is fundamentally flawed, just as it was in the previous MAP litigation.

The City begins by claiming that this Court must defer to the City's interpretation of Section 12-126, even if that interpretation is flawed. City Br. at 38 (arguing that this Court is "required to defer to the statutory interpretations of the City"). That is incorrect. As the First Department held just months ago in the previous MAP litigation, the City's interpretation of Section 12-126 is not entitled to any judicial deference whatsoever. *See NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 210 A.D.3d 559, 559 (1st Dep't 2022) (rejecting City's deference argument and explaining that issues of "statutory interpretation [are] subject to de novo review, and [do] not [] requir[e] deference to the special expertise of respondent agency").

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). 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 providing Medicare-eligible Retirees Medicare plus supplemental insurance.

Before Medicare took effect, the City provided health insurance to all of its employees, retirees, and their dependents pursuant to City Resolution Calendar No. 292 ("Resolution 292"). Resolution 292 "grant[ed] to all of its employees[,] . . . retired employees[, and their dependents] . . . a choice of health plans" and required "the City [to] assume full payment for such health and hospital insurance" up to the cost of the most expensive plan. NYSCEF No. 4 at PDF p.452-53.[9]

Resolution 292 was passed in December 1965, after Medicare was signed into law but before it took effect. *Id*. at PDF p.450. After Medicare went into effect in July 1966, the City continued to provide Medicare-eligible retirees a choice of City-funded plans, but modified its Health Benefits Program so that the plans it offered to Medicare-eligible retirees only supplemented, and did not duplicate, the benefits provided by Medicare. As the legislative history for Section 12-126 states: "When the Medicare program went into effect July 1, 1966, the city's health insurance program, offering a choice of three plans, was modified to remove from it benefits duplicated by Medicare. Consequently, all employees 65 or over had to enroll in Part B of Medicare to obtain the same benefits provided by the city before Medicare." *Id*. at PDF p.448. In other words, under Resolution 292, the City offered Medicare-eligible retirees three plans that supplemented, but did not duplicate, benefits provided by Medicare. *See also id*. at PDF p.519 (noting the City's obligation to pay "[t]he cost of the Medicare supplement" plus "the part B

[9] Resolution 292 continued and extended the healthcare benefits addressed in an earlier resolution (Resolution Calendar No. 155), which used nearly identical language. *See id*. at PDF p.459.

Medicare premium"). At the time, Medicare Advantage plans, which replace both Medicare and supplemental insurance, did not exist and would not exist for another 30 years.

In 1967, the City Council passed Section 12-126, which codified the healthcare benefits—including Medicare supplemental insurance—guaranteed by Resolution 292. *See id*. at PDF p.436 (noting the codification); *New York 10-13 Ass'n v. City of New York*, 1999 WL 177442, at *12 (S.D.N.Y. Mar. 30, 1999) (stating that Section 12-126 "was enacted pursuant to Resolution Cal. No. 292"); Index No. 158815/2021, NYSCEF No. 227 at 2 (City acknowledgment that Section 12-126 "was based" on Resolution 292). Section 12-126 went into effect on January 1, 1968. *Id*. at PDF p.437. Under Section 12-126, as under Resolution 292, the City continued to offer its Medicare-eligible retirees the same choice of three Medicare supplemental plans. As the SPDs in the record reflect, the number of Medicare supplemental options has increased over time.

The text of Section 12-126 makes clear that it was codifying the City's practice of providing Medicare-eligible retirees Medicare supplemental insurance. Section 12-126 states unequivocally that "the ***City*** will pay the ***entire*** cost" of the health insurance plans it offers, up to a statutory cap. N.Y.C. Admin. Code § 12-126(a)(iv), (b)(1) (emphasis added); *see also Campion*, 210 A.D.3d at 560 (holding that "Administrative Code § 12–126(b)(1) requires *respondents* to pay the *entire* cost, up to the statutory cap," of retiree health insurance (emphasis added)). Although the City pays the "entire cost" of Medicare supplemental plans, it does not pay the "entire cost" of Medicare Advantage plans. The federal government pays for Medicare Advantage plans. *See* 42 U.S.C. § 1395w-23. The City may, in its discretion, pay additional fees for special plan features, as the City has agreed to do with the Aetna MAP ($15 per-person-per-month to reduce the list of services subject to prior authorization). However, that does not constitute the "entire cost" of the

plan. Thus, the City cannot satisfy its obligations under Section 12-126 by offering only a Medicare Advantage plan, since it is not paying the "entire cost" of such a plan.[10]

The City Council has never amended Section 12-126 to allow the City to stop offering health insurance plans for which it pays the entire cost. It chose not to do so when Medicare Advantage plans emerged in the 1990s, and it refused to do so when the City proposed an amendment earlier this year. Thus, to allow the City to offer only Medicare Advantage—the entire cost of which is not borne by the City—would violate Section 12-126 and contravene the clear intent of the City Council. City Councilmembers have submitted an amicus brief confirming this. *See* NYSCEF No. 91 at 7.

IV. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR CLAIM REGARDING LIFE-THREATENING DISRUPTION OF CARE

As the roughly 350 affidavits submitted in support of Petitioners' motion confirm, and as the City cannot dispute, many Retirees currently rely on life-saving treatment from medical providers who have said they will not accept the Aetna MAP, and many other Retirees are receiving end-of-life care in continuing care facilities that will not accept it. It is undisputed that all of these Retirees must either: (1) switch providers in the middle of life-saving treatment/care; or (2) pay the Medicare Part B premium and attempt to find and purchase a Medicare supplemental plan on the open market. The first option is incredibly dangerous. The second option is literally impossible for those with uninsurable medical conditions who live in the 46 states that do not

[10] The absurdity of the City's position is demonstrated by the fact that there are many $0-premium Medicare Advantage plans on the open market. *See* Kate Ashford, *Medicare v. Medicare Advantage: Which Should I Choose?*, NerdWallet, https://perma.cc/7Y3L-WF5L (noting that "Medicare Advantage offers many $0-premium plans"). According to the City, it could satisfy its obligations under Section 12-126 by only offering one of these plans. But that is no different from not offering any plans at all, since Retirees could get the exact same plan for the exact same amount on the open market.

guarantee a right to Medicare supplemental insurance; and it is practically impossible for those who cannot afford to pay several thousand dollars a year for health insurance (which is most Retirees). Further, those Retirees who pursue option 2 will not only have to waive City coverage and pay for their own health insurance, they will also have to pay for the health insurance of all of their dependents, since waiving coverage for oneself also waives coverage for all of one's dependents.[11]

Thus, it is undisputed that some number of very sick Retirees will have to (i) switch medical providers mid-treatment, (ii) go without insurance, or (iii) do without basic necessities such as medicine, housing, food, and utilities. Regardless of how high that number is (and Petitioners' research suggests it is quite high), that is an arbitrary, capricious, and inhumane way for any City, let alone the richest City in the world, to treat its terminally ill retirees. The City, Aetna, and the MLC callously brush aside this suffering on the theory that "change always brings with it some disruption." MLC Br. at 9. However, the "disruption" they so casually reference here is potentially life-threatening to many Retirees.

A. The City grossly exaggerates the number of medical providers that will accept the Aetna MAP.

The City offers misleading data to falsely suggest that virtually all medical providers will accept the Aetna MAP. Without any independent analysis of its own, the City claims that Aetna has "concluded that at least 97% of providers who accepted Senior Care have *indicated* they will accept payment from Aetna." City Br. at 30 (emphasis added). "Indicated" is doing all of the work in that sentence, and it gives away that the City and Aetna cannot say for sure how many

[11] *See* NYC Office of Labor Relations - Retiree Special Enrollment/Waiver Form, https://www.nyc.gov/assets/olr/downloads/pdf/health/aetna-ma-docs/2023-retiree-special-enrollment-form.pdf.

medical providers will actually accept the Aetna MAP. Medical providers are the only ones who can say for sure if they will accept the Aetna MAP, and countless medical providers are telling Retirees they either will not accept the plan or do not yet know if they will. *See* Pizzitola Aff., Ex. 1; Pizzitola Aff. ¶ 27; Archer Aff. ¶ 9; Barrios-Paoli Aff. ¶¶ 13, 37, 39; Burns Aff. ¶¶ 7-10; Ryan Aff. ¶ 13. Indeed, when the NYC Organization of Public Service Retirees recently solicited affidavits from Retirees regarding how the Aetna MAP would affect them, a large portion identified at least one of their medical providers who would not accept the plan, and others identified providers who had not yet made up their mind. Moreover, scores of Retirees with cancer and other life-threatening illnesses testified that the medical providers treating them would not accept the plan. This Court should credit the sworn testimony of hundreds of Retirees and experts who have confirmed that a large percentage of medical providers will not accept the Aetna MAP, not the uncertain predictions of the insurance company that stands to make billions of dollars on the plan.

Aetna's 97% figure rests partly on the assertion that 88% of providers who are treating those in Senior Care are supposedly in-network for other Aetna Medicare Advantage plans. City Br. at 30. As an initial matter, that 88% figure is unreliable and likely inflated, as numerous Retirees have testified that Aetna misclassifies out-of-network providers as being in-network.[12] Second, just because providers are in-network for other Aetna Medicare Advantage plans does not mean they will be for this one. Indeed, Aetna itself admits that providers may sign "network contracts . . . only for" a specific Aetna Medicare Advantage plan. Aetna Br. at 13.

[12] *See, e.g.*, Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52-57) at Campbell Aff. ¶ 7, Levy Aff. ¶¶ 9-10, Rosenblum Aff. ¶ 6, Amundsen Aff. ¶ 14, Jukic Aff. ¶ 5, Stromer Aff. ¶¶ 7-9, Feivelson Aff. ¶ 6, Ubell Aff. ¶ 8, Alghren Aff. ¶ 7; Bliss Aff. ¶¶ 9-10, 13-14, Boscia Aff. ¶ 8.

Aetna's 97% figure also rests on the assertion that 8.3% of providers "have accepted payment from Aetna" at some point in the past. City Br. at 30. However, the fact that a provider has accepted payment from Aetna on at least one occasion in the past (and not necessarily in connection with a Medicare Advantage plan) is no assurance that it will accept all patients enrolled in the Aetna MAP, particularly if the provider's past experience with Aetna or Medicare Advantage was negative (which is very common).

Finally, Aetna claims that "hundreds of providers . . . have indicated in discussions with Aetna that they will accept the Aetna MAP." Aetna Br. at 13. Again, however, an "indication" in a "discussion" is far from a binding commitment. Aetna also touts the fact that it has engaged in "negotiat[ions]" or "agreements in principle" with various providers. Aetna Br. 13-14. Absent a binding contract with these providers, Aetna cannot accurately claim they will accept the Aetna MAP.

Aetna's filings are replete with similar unsupported allegations. Aetna claims, among other things, that certain hospitals and health systems will supposedly accept the Aetna MAP. *See* Grantham Aff. ¶ 9. However, when Retirees actually contacted those providers, they have been informed that the providers will not accept the plan or do not know if they will, and, critically, that the ultimate decision whether to accept the Aetna MAP is up to each individual doctor—not the umbrella health or hospital system. Pizzitola Aff., Ex. 1; Pizzitola Aff. ¶ 27. In other words, an entire hospital or health system may refuse to accept the Aetna MAP (thus preventing Retirees from receiving care there), but even if it agrees to accept the plan, that decision is not binding on

the individual doctors.[13] Nor does any of this address the fact that, unlike traditional Medicare, the Aetna MAP will have a limited provider network, which providers can leave at any time.[14] Thus, no Retiree can be sure that any of their providers will accept the plan in the future.

In short, the City and Aetna cobble together misleading data in a transparent attempt to make it appear as if all medical providers will accept the Aetna MAP. The fact remains that when Retirees actually contact their medical providers, they are consistently being told that these providers will not accept the plan. *Id*. There is no more decisive proof than that, and this refutes the City and Aetna's flawed, self-serving prediction regarding the number of providers that will accept the Aetna MAP.

B. Many Retirees will be unable to obtain Medicare supplemental insurance.

Without any citation to any authority whatsoever, the City boldly (and erroneously) claims that "Retirees who are aged 65 or older who lose coverage by choosing to waive coverage under a Medicare Advantage plan will have a guaranteed issue to a Medigap plan or other supplemental coverage on the open market, regardless of preexisting conditions." City Br. at 30-31.[15] With

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[13] Aetna lists a number of hospitals and health systems that allegedly accept the Aetna MAP, but many providers associated with them have said they will not accept the plan. *See, e.g.*, Albano Aff. ¶ 12 (doctors at Special Surgery will not accept the Aetna MAP, regardless of what the hospital itself accepts); Mandelbaum Aff. ¶ 7 (Dana Farber Cancer Institute in Boston will be "out of network" with the Aetna MAP, but the specialist Mandelbaum sees will not accept the Aetna MAP at all).

[14] *See, e.g.*, Center for Medicare Advocacy, *Choosing Between Traditional Medicare and Medicare Advantage*, https://perma.cc/V3AQ-HRTL.

[15] Given the City's track-record of misrepresenting Retirees' healthcare rights, its self-serving assertion that Retirees will be able to access Medicare supplemental insurance should be viewed with appropriate skepticism. In the Retirees' original MAP litigation, the City advanced an interpretation of Section 12-126 that not only was wrong, but also that the City knew (and internally acknowledged) was wrong. *See* Index No. 158815/2021, NYSCEF No. 225. And in the Retirees' ongoing co-pay class action, the City falsely claimed that the Senior Care contract

respect to Retirees under age 65, the City concedes that they have no such guarantee and will be unable to obtain a Medigap plan in many states where they live. *Id*. at 31.

As Petitioners' independent experts all confirm, a right to "Medigap" (*i.e.*, Medicare supplemental) insurance—known as a "guaranteed issue" right—exists under federal law *only* where an employer terminates the health insurance coverage of its employees, not where, as here, the employer switches their health insurance. *See, e.g.*, Burns Aff. ¶ 17 ("[F]ederal law does not guarantee someone access to a Medigap plan when some benefits like a MAP continue to be offered."); Omdahl Aff. ¶¶ 74–77 ("Some insurance agents have been telling retirees that they can get a supplement because Senior Care is ending. However, the retiree coverage is not ending [because] . . . [t]he City is not canceling the retiree coverage; it is changing to a Medicare Advantage plan."); Ryan Aff. ¶ 34 (explaining that Retirees only have a guaranteed issue right in four states). The Kaiser Family Foundation, a non-partisan, widely respected medical authority, reiterates this reality: retirees have a guaranteed issue right only when their employer cancels their coverage; they do not have such a right when the employer changes coverage, or when the retiree waives their coverage. *See* Omdhal Aff. ¶ 76 (citing KFF, Medigap Enrollment and Consumer Protections Vary Across States, https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/).

Over-65 Retirees with uninsurable medical conditions who do not live in one of the four guaranteed issue states therefore will be unable to obtain Medicare supplemental insurance. And, in many states, under-65 Retirees (regardless of their medical conditions) do not have access to Medicare supplemental insurance. All of these Retirees whose medical providers will not accept

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permits co-pays for medical care, an argument that this Court and a unanimous First Department rejected.

the Aetna MAP will have to switch providers in the middle of life-saving treatment, or else continue to see their providers without insurance coverage.

Regardless, even if Retirees could access a Medicare supplemental plan on the open market (which many cannot), most will not be able to afford the staggering cost of such a plan or the $2,000-a-year expense of Medicare Part B. *See, e.g.*, Bentkowski Aff. ¶ 8 (supplemental plan will cost at least $800/month); Pizzitola Aff. ¶¶ 8, 22, 42; Pizzitola Aff., Ex. 1. Over 70,000 Retirees survive on fixed incomes of less than $1,500 a month; nearly 100,000 survive on less than $2,000; and over 150,000 survive on less than $3,000. Barrios-Paoli Aff. at ¶ 33; Pizzitola Aff. at ¶ 8. Thus, the cost of Medicare-plus-supplemental insurance will equal several months' income for most Retirees, an impossible sum.

Lastly, although the City does not advance this preposterous argument, Aetna falsely claims that Retirees who enroll in the Aetna MAP have a guaranteed right to switch back to a Medigap plan within 12 months. Tellingly, rather than directly cite any authority for this incorrect proposition, Aetna cites to an employee affidavit, which in turn cites to a link to a Medicare website.[16] That website states, "If you're not happy with your Medicare Advantage Plan, you'll have a single 12-month period (your trial right period) to get your Medigap policy back if the same insurance company still sells it once you return to Original Medicare." *Id*. Because Senior Care will no longer be offered, this "trial right" is non-existent for Retirees.

[16] *See* Fisher Aff. ¶ 12 (citing https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works#:~:text=%20If%20you're%20not%20happy,you%20return%20to%20Original%20Medicare).

V. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR MORATORIUM LAW CLAIM

The text of the Moratorium Law unambiguously prohibits every school board and district from "diminishing the health insurance *benefits* provided to retirees . . . *or* the *contributions* such board or district makes for such health insurance coverage" unless the board or district makes "a corresponding diminution of benefits or contributions" for active employees. Ch. 729 of the Laws of 1994 (as amended by L 2009, Ch. 30 and L 2009, ch. 501 § 14) (emphasis added). The City does not dispute that it has diminished its contributions toward Retiree health insurance, nor does it dispute that it has diminished retiree health insurance benefits in various material ways. Instead, it adopts a series of atextual arguments that lack any support in the statutory text, caselaw, or otherwise. Each of its arguments is wrong. For the reasons discussed in Petitioners' opening brief (at 39–54) and below, the City has violated the Moratorium Law in two distinct ways: first, by diminishing its *contributions* to retiree health insurance; and second, by diminishing retiree health insurance *benefits*. The City previously paid approximately $2,400 per Retiree per year for a health insurance plan; it will now pay $180 per Retiree per year. Unsurprisingly, this 92.5% payment reduction means that Retirees will receive less in return.

A. The City distorts the Moratorium Law.

The City acknowledges or admits most of the core facts, as discussed below. It therefore resorts to distorting the law plus a few irrelevant facts to try to skirt liability for a straightforward Moratorium Law violation.

First, the City advances as its lead argument that the Moratorium Law was intended to prevent only "drastic changes" to either the contributions to, or benefits of, health plans for retirees. City Br. at 16, 21. Not so. The text of the statute is clear: it proscribes *any and all* diminishments, not only "drastic" ones. *Cf. Patrolmen's Benev. Ass'n of City of New York v. City of New York*,

41 N.Y.2d 205, 209 (1976) (noting that, had the legislature intended a different meaning, "they were free . . . to draft appropriately worded legislation"). Nor does anything in the caselaw reference "drastic" diminishments. The City does not cite a single case (nor are Petitioners aware of any) where a court held that because a reduction to retiree healthcare contributions or benefits was *non*-drastic, it was therefore permissible under the Moratorium Law. To the contrary, courts have found Moratorium Law violations even where the reductions at issue were relatively minor. *See, e.g.*, *Jones v. Bd. of Educ. of Watertown City Sch. Dist.*, 30 A.D.3d 967, 970 (4th Dep't 2006) (Moratorium Law violation where school district reduced its contributions to retiree health insurance premiums by 10%, while reducing contributions for active employees by 4%).

Rather than cite the statute's text or any of its interpreting caselaw, the City instead cites oblique legislative history that describes the precarious position of Retirees, who can no longer collectively bargain and who are vulnerable to the whims of a public employer motivated to find cost savings at their expense. The City truncates the full breadth of the legislative history when it argues that the bill was intended to protect only against "drastic changes"; in fact, a full read of the legislative history makes clear that the Moratorium Law protects Retirees against any diminishment of their health plans, large or small. *See, e.g.*, NYSCEF No. 87 (City Ex. 5) at PDF pp.6, 9 (stating that the law prohibits "reducing" retiree healthcare benefits "below that presently provided to retirees and their beneficiaries"). Even if the legislative history supported the City's interpretation—which it does not—such history could not trump the plain language of the statute. *See Avella v. City of New York*, 29 N.Y.3d 425, 437 (2017) ("The plain language of the statute does not authorize the proposed construction, and we therefore need not consider the legislative history."). Moreover, even the Moratorium Law required a "drastic" change in benefits—which it does not—the changes from Senior Care to the Aetna MAP *are* drastic. *See* Petrs.' Op. Br. at

13, 17–20, 36–39 (detailing how the Aetna MAP is drastically inferior to Senior Care); Omdahl Aff. ¶¶ 1, 6, 8, 19, 33-48, 59, 62-63, 100 (same).

Second, the City claims that the Moratorium Law should not apply to it because at the time the statute was passed, retiree benefits were better than active employee benefits. According to the City, this creates an exception for the City because the Legislature supposedly had an unwritten "baseline assumption" that active employees and retirees had the *same* health insurance benefits. The City argues that it is therefore allowed to reduce the contributions to and benefit levels of retiree health insurance without *any* corresponding reduction for active employees (contradicting the plain meaning of the Moratorium Law's text), so long as those contributions and benefits for Retirees do not drop below the level provided to active employees. City Br. at 17, 28–29. Not surprisingly, the caselaw *directly* contradicts this argument: courts have found Moratorium Law violations even where school districts equalized the healthcare of retirees and active employees. In *Watertown*, for example—the only Appellate Division holding on point, and therefore binding on this Court—the school district had been paying 100% of retirees' health insurance but only 94% of active employees' health insurance. The district then reduced payment for active employees' health insurance to 90%, and a decade later attempted to equalize everyone's healthcare by paying 90% for retirees as well. *See* 30 A.D.3d at 968-70; *see also Jones v. Bd. of Educ. of Watertown City Sch. Dist.*, 6 Misc. 3d 1035(A) (Sup. Ct. Jefferson Cty. 2005) (explaining the changes). The Fourth Department held that this was a violation of the Moratorium Law—despite the equalization—because the diminution to retirees' healthcare (10%) was greater than the diminution to active employees (4%). *Id.* Thus, even if the Moratorium Law provides a *second* measure of protection for Retirees by prohibiting their healthcare from being worse than active employees' healthcare (as alluded to in dicta from cases cited by the City), the statute's *primary*

requirement is that the contributions and benefits to Retirees cannot be reduced *at all* unless there is a *corresponding* reduction for active employees.[17]

Third, the City advances an interpretation of the Moratorium Law that would permit reductions in contributions and benefits for Retirees (without a corresponding reduction for active employees) so long as the "overall level" of benefits are not reduced and the costs to Retirees are not "dramatically increase[d]." City Br. at 16, 22, 23–24. The City cites no authority for either of these quoted standards. Further, it criticizes Petitioners for focusing on specific changes to their healthcare, including increases in co-pays and prescription drug costs, restricted access to medical providers and medications, the prospect of having to pay the full cost of medical care when coverage is denied or the provider bills the Retiree directly, and the imposition of prior authorization requirements. But these are critically important changes. Thus, even under the made-up standards proposed by the City, Petitioners have demonstrated a Moratorium Law violation because Retirees face a decrease in their "overall level" of benefits and a "dramatic increase" in potential costs.

Lastly, as discussed in the next subsection, the City essentially asks this Court to ignore the text of the Moratorium Law prohibiting school boards and districts from "diminishing the . . . *contributions* such board or district makes," and to instead insert new words into the statute to arrive at the City's preferred language, which would proscribe only "diminishing the *proportion*

[17] In a related argument, the City claims that it is entitled to a "more nuanced application" of the law because it believes that, historically, the City offered better benefits to retirees than other municipalities did. City Br. at 22–23. But the City cites nothing—no text, no caselaw, not even legislative history—in support of this assertion. And in fact, the City's argument is also directly refuted by the legislative history of the 1994 bill, which includes a letter by Mayor Giuliani to Governor Cuomo, in which Mayor Giuliani urges the governor to veto the bill, making clear that Mayor Giuliani understood that the Moratorium Law would apply, in full, to New York City. *See* NYSCEF No. 87 (City Ex. 5) at PDF p.19.

of contributions such board or district makes." Once again, the City cites no cases in which courts interpreted the statute in this way. The City's argument contravenes the Moratorium Law's clear text and finds no support in the caselaw.

In sum, the City asks this Court to disregard the statute's plain text, ignore common sense, and interpret the law in a way that no court has done before. For the reasons discussed herein, this Court should reject the invitation.

B. The City has unlawfully diminished its <u>contributions</u> to Retirees' health insurance without a corresponding diminution for active employees.

The City has plainly diminished its *contributions* to Retiree health insurance without a corresponding diminution for active employees. It previously paid approximately $2,400 per year per Retiree for a health insurance plan; it will now pay only $180.[18] No corresponding diminution has been made for active employees, a fact the City does not dispute. Instead, the City adopts a convoluted interpretation of "contributions," claiming that it means "the *proportion* of health insurance premiums borne by [the] district." City Br. at 18 (emphasis added).

In other words, the City is advancing the argument that even though it will pay $180 per year instead of $2,400 per year, this is not, in fact, a diminution in "contributions" at all. This wholly atextual interpretation, which has no support in caselaw either, is wrong. The text of the Moratorium Law is unambiguous: it prohibits school districts from "diminishing . . . the contributions such board or district makes for such [retiree] health insurance coverage," and says nothing about the proportion of contributions. "[W]here the language of a statute is clear and

[18] Any additional contribution by the federal government is irrelevant to the Moratorium Law analysis, in part because the strings attached to taking those federal funds necessitate the City placing the Retirees in an inferior health plan. The City is reducing its contributions because it found a cheaper health insurance option with increased financial and medical risks to Retirees. That is a shift in cost to the Retirees (in addition to being a reduction in benefits).

unambiguous, courts must give effect to its plain meaning." *State v. Patricia II*, 6 N.Y.3d 160, 162 (2006). According to the plain meaning of the statute, the City has violated the Moratorium Law. The legislative history also supports Petitioners' interpretation: it repeatedly states that, in order for "school districts [to] tak[e] cost-cutting measures," those measures must "apply *equally* to active employees and retirees." Gardener Aff., Ex. P at McKinney's 2004 Session Laws of New York (emphasis added). It is undisputed that the City's cost-cutting measures here apply *only* to Retirees.

The City has not cited any case—and Petitioners are aware of none—where a court interpreted the Moratorium Law to focus only on the "proportion" of health insurance costs borne by the district.[19] None of the cases cited by City says anything, not even in dicta, to this effect.

But even if the proportion of contributions were relevant, the City itself admits that the proportion of healthcare costs borne by retirees does not mean the monthly *premium* for a health insurance plan, but rather the *total cost* of health insurance. *See* City Br. at 20 ("[S]everal cases have found violations where school districts ceased reimbursing retirees for Medicare premiums *and/or surcharges, effectively increasing the portion of premiums borne by retirees*." (emphasis added)). And under this metric, Retirees have amply shown they will incur greater monthly costs through, among other things, increased co-pays for medical services, increased prescription drug costs, and expenses incurred when Aetna denies coverage retrospectively and when providers bill Retirees directly.

[19] Rather than cite any supporting Moratorium Law caselaw, the City resorts to citing a series of irrelevant cases about competitive bidding laws and misrepresents Petitioners' arguments. City Br. at 19. Petitioners do not argue that health plans must be "fr[ozen] . . . in perpetuity." *Id*.

The Aetna MAP's marginally lower deductible and $1,500 cap on certain out-of-pocket costs do not change the fact that Retirees will pay more, because under Senior Care *essentially all costs are covered after the modest $276 deductible is met*—meaning that Retirees generally pay no more than $276 a year for medical services. *See, e.g.*, Omdahl Aff. ¶ 40.[20] Under the Aetna MAP, Retirees will have to pay up to $1,500, plus the increased cost of drugs, plus the cost of medical services for which Aetna denies coverage, plus the cost of services for which providers bill Retirees directly.

Retirees who wish to maintain the same level of coverage and benefits, moreover, will be forced to opt out of the Aetna MAP and pay several thousand dollars a year for a Medicare supplemental plan on the open market (assuming they pass underwriting). They will also have to pay approximately $2,000 a year for the Medicare Part B premium, as well as any Income-Related Monthly Adjustment Amount ("IRMAA") surcharges, which the City will no longer reimburse. *See* Barrios-Paoli Aff. ¶ 47. This too constitutes a Moratorium Law violation. *See Bailenson v. Bd. of Educ.*, 194 A.D.3d 1039, 1039-41 (2d Dep't 2021) (Moratorium Law violation where school district ceased reimbursement of IRMAA surcharge on Medicare Part B premiums); *Baker v. Bd. of Educ.*, 29 A.D.3d 574, 575 (2d Dep't 2006) (Moratorium Law violation where school district ceased reimbursement of Medicare Part B premiums); *Bryant*, 29 Misc.3d at 710 (same).

The City has therefore violated the Moratorium Law by diminishing its contributions to Retiree health insurance without any corresponding diminishment for active employees.

[20] Senior Care has co-pays for emergency room care.

C. The City has unlawfully diminished benefits for Retirees without a corresponding diminution for active employees.

The City's reduction in contributions will also result in a diminishment of *benefits* for Retirees. Unsurprisingly, cheaper health insurance plans have worse benefits. The City tries to obfuscate this reality by claiming that the Aetna MAP has certain "additional" benefits (which, it should be noted, are *not* healthcare benefits) and that active employees have also faced changes to their health insurance. Neither saves the City from a Moratorium Law violation.

Petitioners have demonstrated that implementation of the Aetna MAP will lead to a diminishment in Retiree benefits. *See* Petrs.' Op. Br. at 13, 17–20, 36–39 (detailing how the Aetna MAP is drastically inferior to Senior Care); Omdahl Aff. ¶¶ 6, 8, 19, 33-48, 62-64, 100 (same).[21] Such diminishment includes increased co-pays and prescription drug costs, restricted access to medical providers and medications, the prospect of having to pay the full cost of medical care (when Aetna denies coverage or the provider refuses to bill Aetna), and the imposition of prior authorization requirements. These are far worse than any changes made to active employee health insurance.

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[21] The City argues that Petitioners' instant motion should be denied because (according to the City) Petitioners have not conclusively proven all of the facts demonstrating a reduction in benefits. City Br. at 22. But to obtain a preliminary injunction, Petitioners need demonstrate only "[a] prima facie showing of a reasonable probability of success . . .; actual proof of the petitioners' claims should be left to a full hearing on the merits." *Barbes Rest. Inc. v. ASRR Suzer 218, LLC*, 140 A.D.3d 430, 431 (1st Dep't 2016). A likelihood of success on the merits may be sufficiently established "even where the facts are in dispute and the evidence need not be conclusive." *Id.* Regardless, Petitioners have met their burden even under the case cited by the City, *Anderson v. Niagara Falls City Sch. Dist.*, 125 A.D.3d 1407 (4th Dep't 2015)—which was decided on the merits, not at the preliminary injunction stage. Petitioners have introduced extensive documentary evidence regarding the benefits provided to Retirees and active employees, including the affidavits of health insurance experts detailing how the Aetna MAP will diminish Retiree benefits. *See, e.g.*, Omdahl Aff. ¶¶ 1, 6, 8, 19, 33-48, 59, 62-63, 100. Petitioners have likewise introduced hundreds of affidavits from Retirees explaining the same. *See generally* Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52–57) (approximately 350 Retiree affidavits).

Nothing in the Aetna MAP makes up for these diminishments. The marginally lower deductible and out-of-pocket cap, as noted above, do not prevent Retirees from incurring substantially higher costs overall. And the supposed "additional benefits" provided by the Aetna MAP—transportation, fitness programs, and wellness incentives—are not healthcare. If a Retiree can no longer see the doctor treating her for cancer, a fitness program or wellness incentive is useless because she will be too sick to use it. *See, e.g.*, Feivelson Aff. ¶ 6 (doctors treating her for metastasized cancer will not participate in the Aetna MAP); Zulferino Aff. ¶¶ 1, 7 (suffering from 9/11-related lung issues and none of his doctors will accept the Aetna MAP); Odze Aff. ¶¶ 7, 8 (doctor treating him for 9/11-related cancer will not accept any Medicare Advantage plan). These types of fringe perks do not compensate for the drastic reduction in care under the Aetna MAP.

The Aetna MAP reduces benefits in numerous ways. Petitioners have focused on four of those: (1) co-pays; (2) the elimination of choice and access to care; (3) the imposition of prior authorization; and (4) reduced prescription drug benefits. Each is addressed below.

i. Co-pays.

The City does not dispute that Retirees will face increased co-pays for medical care under the Aetna MAP. Nor does it dispute that increased co-pays constitute a diminishment of benefits for Moratorium Law purposes. *See, e.g.*, *Anderson*, 125 A.D.3d at 1407–09 (finding a Moratorium Law violation where retirees were transferred from a traditional Medicare plan that had no co-pays for in-network services to a Medicare Advantage plan with co-pays for such services).

Boxed in by these facts, the City seeks an escape by arguing that active employees have also faced increased co-pays. But the City's own submission makes clear that active employees have not faced a corresponding increase. The City cites only one plan for active employees—out of the dozen available to them, *see* NYSCEF No. 4 at PDF p.426—that have increased any co-

pays. Indeed, the co-pays in many plans did not go up, and some of the active employee health plans still have no co-pays for medical services. *See* Petrs.' Op. Br. at 43–44. Because active employees retain a choice of approximately a dozen plans, those employees for whom co-pays constitute a barrier to care (as is the case for many Retirees who require, among other things, frequent specialist visits) can elect a plan without, or with lower, co-pays. Retirees will soon have no such option.[22] Thus, there has been no "corresponding" diminishment of this benefit for active employees, which constitutes a violation of the Moratorium Law.

ii. Elimination of choice and access to care.

It is undisputed that the Aetna MAP, unlike Senior Care, will have a limited provider network. The City also does not dispute that access to a larger pool of providers constitutes a "benefit" of a health insurance plan.[23] Instead, the City plays games with statistics, trying (but failing) to demonstrate that the Aetna MAP will not force Retirees to either change providers or pay more to see their current providers. The Aetna MAP will do both.

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[22] The City obfuscates this reality by claiming that no co-pays for active employees are available only for certain "preferred" providers, and that "certain providers are also exempt from co-pays under the HIP VIP plan." City Br. 24–25. But these statements are misleading. HIP VIP covers an extremely limited geographic area, such that most Retirees could not access it even if they wanted to. The relevant question is whether any "preferred providers" exist under the Aetna MAP—and the answer to that is no. In addition, it is not only active employees' "preferred providers" who have no co-pays: under the MetroGold plan, for example, there are no co-pays for *all* in-network providers. *See, e.g.*, The Official Website of the City of New York, Summary of Benefits and Coverage, *MetroPlus Gold: MetroPlus Health Plan*, https://perma.cc/C34P-E37D.

[23] The City tries to dispute only that *choice* is a benefit by relying on cherry-picked dictionary definitions. But numerous definitions of "benefit" support Petitioners' argument. *See, e.g.*, Merriam-Webster, https://www.merriam-webster.com/dictionary/benefit (defining "benefit" as "something that produces good or helpful results or effects or that promotes well-being"); Cambridge Dictionary, https://dictionary.cambridge.org/us/dictionary/english/benefit (defining "benefit" as "a helpful or good effect, or something intended to help"). Choice of health insurance coverage undoubtedly constitutes something "good," "helpful," or one that "promotes well-being."

The hundreds of Retiree affidavits submitted by Petitioners directly refute the City's prediction that 97% of providers will accept the Aetna MAP. *See* Pizzitola Affidavit, Ex. 1 (Doc. Nos. 52-57). As discussed in Part IV(A), *supra*, Aetna's 97% figure is based on misleading and unsupported assumptions. In reality, many providers will not accept the Aetna MAP, and those that decide to accept it in September could change their mind at any time.

Contrary to the City's contention (City Br. at 27), Petitioners have identified numerous medical providers by name who will not accept the Aetna MAP. *See, e.g.*, Omdahl Aff. ¶¶ 52-53 (Mayo Clinic, Stanford University Hospital); Saxenberg Aff. ¶ 9 (Mayo Clinic in FL); Ansaldi-Klyvert Aff. ¶ 5 (Mayo Clinic in AZ); Pecorella Aff. ¶ 6 (Mayo Clinic); Schonfeld Aff. ¶ 6 (Mayo Clinic in Rochester, MN); Dooley Aff. ¶¶ 10-11 (Mayo Clinic in Phoenix, AZ); Gardener Aff., Ex. Q (affidavit of Dr. Markison stating that he serves Retirees and does not accept any Medicare Advantage plan, and that the same is true of many of his colleagues). The City does not dispute that these providers will not accept the Aetna MAP. Numerous other Retirees have also identified their medical providers by name. *See generally* Pizzitola Aff., Ex. 1 (NYSCEF Nos. 52–57).

Eliminating Retirees' existing health insurance will force many to find new providers or to pay out-of-pocket to keep their existing providers. Active employees, on the other hand, are virtually guaranteed access to the same providers because their plans have not changed, and because, even if their plan dropped their provider, they have a dozen plans from which to choose. If for any reason one plan no longer serves their needs, or a key provider stops taking one type of insurance, they can switch to another plan that better serves them.

In sum, the City will diminish an important benefit for Retirees with no corresponding diminishment for active employees.

iii. Prior authorization.

The City is wrong when it argues that the imposition of prior authorization does not constitute a reduction in "benefits" because it "does not change the scope of items or services covered." City Br. at 28. That is *exactly* what prior authorization does: by interposing the insurance company between the Retiree and her doctor, the insurance company reduces the scope of items and services covered. *See, e.g.*, Burns Aff. ¶ 12 ("Prior authorization is a very serious barrier to care that 'limits' the number of diagnostic tests and procedures that can be easily accessed."); Barrios-Paolo Aff. ¶ 15 ("Prior authorization is the practice used by private insurance companies to step between a doctor and her patient. . . . In reality, it is often used to limit access to medical care."); Ryan Aff. ¶ 31 ("[P]rior authorization . . . lead[s] to denials or delays in care."); Omdahl Aff. ¶ 6 (same).

Contrary to the City's contention, prior authorization is not part of Senior Care or traditional Medicare. Traditional Medicare requires prior authorization only under very narrow circumstances, namely for "durable medical equipment," such as at-home hospital beds, and "[p]rocedures that could be considered cosmetic." Omdahl Aff. ¶¶ 1, 7; Barrios-Paoli Aff. ¶ 15. "The important point is [that, under Senior Care,] retirees do not face prior authorization for most medically necessary services that they need," while under the Aetna MAP they will. Omdahl Aff. ¶¶ 1, 8.

The City and Aetna both concede that the Aetna MAP requires prior authorization for numerous medically necessary services. These include acute hospital inpatient stays; long-term acute care; acute physical rehabilitation; skilled nursing facilities care; home care services; various medications; new drugs, therapies, and technologies (none of which are described, defined, or limited, *see* Omdahl Aff. ¶ 17–18); and services that could be considered experimental or

investigational in nature. Moreover, the contract between the City and Aetna identifies only 353 CPT/HCPSC codes in five categories that will be waived initially—out of over 10,000 possible codes covering various medical services and procedures. Omdahl Aff. ¶¶ 12-13. And many common procedures—including many types of x-rays, as well as physical therapy treatment—are notably absent from the City's waiver list. *Id*. ¶¶ 14–15.

The imposition of prior authorization axiomatically will result in care and benefits being reduced, because authorization is often denied. Aetna denies 12% of prior authorization requests, which is the highest prior authorization denial rate in the insurance industry. *See* Petrs.' Op. Br. at 12; Omdahl Aff. ¶ 6. Aetna's "claims data" (cited by the City at page 28 of their brief) confirms this. *See, e.g.*, Moffit Aff. ¶ 17 (admitting that Aetna's prior authorization denial rate was the same 12% cited in Petitioners' opening brief). Aetna also has a long, and well-publicized, track record of denying critical care.

The City seeks to evade liability by noting that prior authorization has always been a feature of certain active employee plans. It contends, in essence, that the Moratorium Law permits the City to single out Retirees for a unilateral reduction in benefits if active employees never enjoyed those specific benefits. But the Moratorium Law does not permit that. As discussed above, an Appellate Division holding directly on point makes clear that the Moratorium Law looks *only* to whether a "corresponding diminution of benefits or contributions is effected from the present level during this period," *i.e.*, during the period set forth in the Moratorium Law, for active employees. *Watertown*, 30 A.D.3d at 969 (quoting Ch. 729 of the Laws of 1994) (emphasis added). *Watertown* held that even though the school board had merely *equalized* the benefits between retirees and active employees, it had violated the Moratorium Law because the diminishment for retirees was greater than any corresponding diminution for active employees. *Id*. at 970. The unprecedented

imposition of prior authorization on Retirees is a dramatic—and frightening—shift in their healthcare. There has been no corresponding change—with respect to prior authorization or otherwise—for active employees.

In addition, the prior authorization faced by Retirees will be worse than that faced by active employees. As noted above, Aetna has the worst prior authorization practices of any insurer. But only *one* of the plans offered to active employees is from Aetna. *See* NYSCEF No. 4 at PDF p.426. Active employees therefore retain a choice of numerous other plans from insurers with lower denial rates and more honest practices,[24] including the non-profit insurer EmblemHealth—whereas Retirees do not.

Accordingly, the City has reduced the benefits provided to Retirees without a corresponding reduction for active employees, which is a violation of the Moratorium Law.

iv. Prescription drug benefits.

Retirees will also suffer a reduction in prescription drug benefits. The City does not dispute that, under Senior Care, Retirees have a choice in prescription drug riders, and that they will lose that choice under the Aetna MAP. The element of choice is important when it comes to a drug rider because different Retirees take different medications and have different levels of coverage (if any) through their unions. A choice in drug riders therefore permits Retirees to choose the plan that works best for them and their medical needs.

Nor does the City dispute that Aetna's drug rider costs more than the drug riders presently available to Retirees. It also does not dispute that the drugs identified by Retirees will, in fact, cost more under the Aetna plan. And it does not dispute that Aetna will impose prior authorization

[24] *See, e.g.*, The Official Website of the City of New York, NYC Health Benefits Program Summary of Benefits and Coverage (SBC), https://perma.cc/R9D8-LJ6E.

requirements on numerous drugs, whereas Senior Care does not. These are all major reductions in benefits.

The five drugs identified in Petitioners' opening brief are merely illustrative.[25] Given the literally thousands of drugs taken by hundreds of thousands of Retirees, it is not possible at this early stage to provide an exhaustive list of every drug that will cost more, but numerous other Retirees will face increased costs for additional drugs. *See, e.g.*, Nielsen Aff. ¶ 7 (cost of Eliquis 5mg will increase by $20/month; Diltiazem 120mg will increase by over $50/month; Symbicort will increase by $12/month); Zulferino Aff. ¶ 8 (Ozempic, which he takes for diabetes, will cost $25 more per month; Bystolic costs $100 more per month; Ranexa will cost ***seven hundred dollars*** more per month); Mandelbaum Aff. ¶ 8 (monthly cost of Zanabrutinib will increase by $1,000/month, to $15,000 per month, and he is unable to determine if his share of that cost will be 25% or 5% because Aetna keeps giving him different answers); Dunn Aff. ¶ 7 (Eliquis will cost $72 more per month).

Other Retirees, moreover, take drugs for which the Aetna MAP does not provide *any* coverage, and/or requires prior authorization, and/or requires them to use another drug first, which for many Retirees is incredibly dangerous. *See, e.g.*, Bigelisen Aff. ¶ 7 (noting that all of the medications she takes, including an anti-seizure drug, fall under at least one of these categories); Raskin Aff. ¶ 9 (Eylea, without which he will go blind and for which he is currently covered, costs $4,000-$6,000/month, and is not covered under the Aetna MAP); Gonzalez Aff. ¶ 8 (Tirosint, which she takes for thyroid cancer, is not in Aetna's formulary; Effexor requires preauthorization;

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[25] That two of the drugs "were not approved until . . . after the enactment of the Moratorium Law," City Br. 25 n.7, is irrelevant. The Moratorium Law requires only an analysis of whether Retiree benefits have been diminished. These drugs will cost more under the Aetna MAP than they have under Senior Care. That constitutes a diminishment of benefits.

and Ozempic is much more expensive); Macdonald Aff. ¶ 7 (Gammunex-C requires prior authorization); Weiss Aff. ¶ 19 (Vyepti not found on Aetna's list).

The Aetna drug rider's increased costs will affect numerous Retirees. Many Retirees receive no union welfare benefits at all, and others need medications that exceed their union coverage. Consider the example of William George Shenton. He has union coverage, but that coverage is limited to $33,500. Shenton Aff. ¶ 5. His dependent wife suffers from an incurable autoimmune disease requiring medication that has totaled $56,483 so far this year. *Id.* Under her current Senior Care drug rider, which costs only $28.30 per month, she has had to pay only $5,353 of that amount. *Id.* Under the Aetna MAP, she will have to pay more for this medication, and both she and Mr. Shenton will have to pay the SilverScript premium, which is approximately $200 more per month. *Id.*

Contrary to the City's contention, the cost and coverage of prescription drugs under the Aetna MAP is relevant to the Moratorium Law analysis with respect to both prongs of the statute (contribution and benefits). With respect to the first prong (contribution), a higher premium for Aetna's compulsory drug rider means that the City is contributing a smaller amount (on both an absolute and percentage basis) for Retiree healthcare. With respect to the second prong (benefits), the problems wrought by the Aetna MAP and SilverScript—which include higher drug costs, a lack of coverage for certain drugs, and new prior authorization requirements—constitute a diminution in benefits.

The City states that the relevant question under the Moratorium Law is "the effect of any changes on the retirees." City Br. at 20–21. The effect here is indisputable: the unrebutted evidence is that the Aetna drug rider will cost more and erect dangerous new barriers to care.

v. Changes to active employees' health insurance are not comparable.

The only diminishment to active employees' health insurance that the City and the MLC identify is various increases in co-pays for a minority of plans, and the fact that active employees have always faced some measure of prior authorization. For the reasons discussed above, these facts do not defeat Petitioners' Moratorium Law claim. But even assuming, for the sake of argument, that the City could identify a corresponding diminishment with respect to co-pays and prior authorization—which it has not—neither the City nor the MLC cite any comparable diminishment for active employees regarding the two other types of benefits at issue here (prescription drug benefits and choice of/access to providers). The undisputed absence of a comparable diminishment of those benefits constitutes a violation of the Moratorium Law.

In conclusion, the City mispresents both the Moratorium Law and Petitioners' arguments. Petitioners do not argue that the Moratorium Law was intended to require "the same health insurance plan . . . ad infinitum." City Br. at 18. Nor do Petitioners argue that the statute "prevent[s] plan redesign and renegotiation for cost savings." City Br. at 19. Petitioners simply argue what the statutory text, legislative history, and caselaw make clear: the City cannot cut costs on the backs of the Retirees without a corresponding diminution for active employees.

That is exactly what the City is doing here. The City will reduce its contributions to Retiree health insurance by 92.5% and, as a result, Retirees will bear the costs. Retirees who remain in the Aetna MAP will pay up to $1,224 more per year for covered medical care, plus much more because the Aetna MAP covers fewer services. Retirees will also pay hundreds, if not thousands, of dollars more in prescription drug costs. And they will receive worse care because they will face prior authorization barriers and a reduced provider network (with many of the best doctors refusing to accept the plan since they can afford to be selective). Retirees who choose to maintain the same

level of care will pay many thousands of dollars per year for a Medicare supplemental plan, as well as approximately $2,000 per year for the Medicare Part B premium. Because these harms will only befall Retirees, who are the sole target of the City's massive and unprecedented cost-cutting scheme, the City's actions violate the Moratorium Law.

VI. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR CAPA CLAIM

The City does not dispute that the unprecedented new healthcare policy announced by the Office of Labor Relations ("OLR") on March 10 satisfies CAPA's general definition of a "rule." Nor does the City dispute that it also satisfies one of the specific statutory examples of a "rule" because it sets new "standards for the granting of . . . benefits." CAPA, § 1041(5)(a)(vii). The City also does not dispute that it did not comply with CAPA's procedural requirements.

The City's entire defense on Petitioners' CAPA claim is that its new healthcare policy fits within the narrow statutory exception for a "statement or communication which relates only to the internal management or personnel of an agency which does not materially affect the rights of or procedures available to the public." CAPA, § 1041(5)(b)(i). This exception does not apply here.

First, courts have rejected the City's argument that a government policy regarding its retired public employees "is a matter of internal agency management and does not affect the general public . . . [since they] are not the 'public' at large." City Br. at 49, 51. In *Connell v. Regan*, 114 A.D.2d 273 (3d Dep't 1986), the question presented was whether a policy implemented by the New York State Employees' Retirement System ("ERS") requiring retirement application withdrawals to be in writing involved only the "internal management" of ERS, thereby exempting

it from the procedures required for agency "rules."[26] The court answered with an unqualified "No." It held that "[r]ules . . . of the retirement system that affect a member's property interest in his or her job may not properly be said to involve matters of 'organization or internal management'" because such rules and regulations "affect all State employees who are members of ERS, that *segment of* the 'general public' over which ERS exercises direct authority, and constitute a quasi-legislative norm or prescription which establishes a pattern for the future." 114 A.D.2d at 275-76 (emphasis added). So, too, here the decision to withdraw long-promised retirement benefits to members of the City's retirement system affects substantial rights of a "segment of the general public" and "establishes a pattern for the future."

Other courts have reached a similar conclusion. *See, e.g.*, *Hill v. N.Y. State Teachers' Ret. Sys*., 97 Misc. 2d 95, 101-02 (Sup. Ct. Albany Cty. 1978) (concluding that New York State Teachers Retirement System's procedure for calculating effective date of retirement was a "rule" because it "d[id] not relate solely to the organizational or internal management" of the agency, and holding that the rule was invalid because the statutorily required procedures were not followed); *Baker v. Com*., 2007 WL 3037718, at *32 (Ky. App. 2007) (finding that a policy concerning the State's contributions toward health insurance premiums for state retirees who returned to other state employment was an administrative regulation and did not fit within an exception for decisions "concerning only the internal management of an administrative body and not affecting private rights or procedures available to the public" because the policy did *not* concern "only the internal

[26] *Connell* involved Executive Law § 102, which requires that "rules" under the State Administrative Procedure Act be filed with the Secretary of State. Like CAPA, it contains an exception for "rules" relating to "internal management."

management" of the agency and "*did* 'affect[] private rights' of [the plaintiff] and all retirees similarly situated" (emphasis in original)).

Second, the CAPA exception on which the City relies is narrow in the sense that "the statement or communication" in question must "relate[] *only* to the internal management or personnel of" the City agency. CAPA, § 1041(5)(b)(i) (emphasis added). Here, OLR's March 10 "statement or communication" announcing the switch from Medicare to Medicare Advantage does not relate at *all* to the "internal management or personnel" of OLR, and it certainly does not "relate *only*" to such internal management or personnel. That is because the new healthcare policy will affect: (1) hundreds of thousands of *retired* City workers, none of whom are employed by any City agency and the vast majority of whom were never employed by OLR; and (2) tens (if not hundreds) of thousands of their *dependents*, who have never worked for the City.[27] As stated by cases the City itself cites, where, as here, "outside individuals are substantially affected," the internal-management-or-personnel exception—which is to be "narrowly construed and only reluctantly countenanced"—does not apply. *Tunik v. Merit Sys. Prot. Bd.*, 407 F.3d 1326, 1343-44 (Fed. Cir. 2005) (cited by the City) (refusing to apply exception in case involving rule directed at current government employees because it also affected others); *see also Conyers v. Sec'y of Veterans Affs.*, 750 F. App'x 993, 997-98 (Fed. Cir. 2018) (cited by the City) (refusing to apply exception to Department of Veterans' Affairs' rule authorizing "a new group of personnel . . . to render services and make determinations related to veterans' benefits" because it "will substantially affect outside

[27] The new healthcare policy will strip all Medicare-eligible dependents of their Medicare-plus-supplemental insurance; it will also affect other (non-Medicare-eligible) dependents because retired City workers who opt out of the Aetna MAP will lose City coverage for themselves and *all* of their dependents. *See* New York City Office of Labor Relations - Retiree Special Enrollment/Waiver Form, https://www.nyc.gov/assets/olr/downloads/pdf/health/aetna-ma-docs/2023-retiree-special-enrollment-form.pdf.

individuals"); *Joseph v. U.S. Civ. Serv. Comm'n*, 554 F.2d 1140, 1153 n.23 (D.C. Cir. 1977) ("[A]lthough the Commission's regulation is only directed at government personnel it does not fall within [the internal-management-or-personnel exception] because outside individuals are substantially affected."); *Seaboard World Airlines, Inc. v. Gronouski*, 230 F. Supp. 44, 46 (D.D.C 1964) ("[T]he policy involved here, although it is directed to the Post Office personnel, substantially affects outside parties and is therefore NOT subject to the exception.").

The cases relied on by the City do not help it. In three of those four cases, the courts held that the internal-management-or-personnel exception did *not* apply. *See Tunik,* 407 F.3d at 1343-44; *Conyers,* 750 F. App'x at 997-98; *Dubendorf v. N.Y. State Educ. Dep't*, 97 Misc.2d 382, 394 (Sup. Ct. Monroe Cty. 1978).[28] And the fourth case, *Matter of Karl v. N.Y.C. Dep't of Citywide Admin. Servs.*, 21 Misc.3d 1131(A) (Sup. Ct. N.Y. Cty. Sept. 24, 2008), is easily distinguishable: it involved "exam filing periods" that were "set [by the Department of Citywide Administrative Services] to facilitate the internal management of the agency."[29]

In fact, the City's cases affirmatively undermine its argument. For example, the City relies on the U.S. Attorney General's Manual on the federal Administrative Procedure Act quoted in *Tunik*. City Br. at 50. However, the City omits the key language from the Manual. The Manual states that the internal-management-or-personnel exception only applies to "an agency's internal personnel and budget procedures," meaning its "rules as to leaves of absence, vacation, travel,

[28] The City misrepresents the holding in *Dubendorf*. It claims that the court "f[ound] a State agency's own internal auditing procedures and instructions [to be] exempt." City Br. at 51. That is the opposite of what the court held. *See* 97 Misc.2d at 393-94.

[29] The court also held that, unlike the exam filing periods, "[t]he standard by which the applicant will be judged, including the experience requirement for a license, is a rule." 21 Misc.3d 1131(A), at *4-5. The City, however, complied with CAPA with respect to this rule.

etc.," which are clearly not at issue in this case. *Tunik*, 407 F.3d at 1342. The Manual further states that "in case of doubt as to whether a matter is or is not one of internal management, it is suggested that the matter [not be treated as one of internal management]." *Id*. Thus, according to the Manual that the City relies on, if there is any doubt as to whether the exception applies in this case, the Court should decline to apply it. The City also relies on *Conyers*, which held that "[t]he personnel exception" applies to "employee bonuses, the promulgation of a personnel manual or handbook, and hiring practices." *Conyers,* 750 F. App'x at 997. None of those things are at issue in this case.[30]

The City cannot point to any case holding that the internal-management-or-personnel exception applies to facts even remotely similar to those present here. Indeed, the City does not cite, and Petitioners have not found, any case (in New York or elsewhere) in which the exception was applied to an agency rule directed at individuals (here, the Retirees and their dependents) who were not then working for the agency and, for the most part, had never worked for the agency. In every one of the cases Petitioners are aware of where the exception was analyzed in the context of retirees, courts refused to apply it. *See, e.g.*, *Connell*, 114 A.D.2d at 275-76; *Hill*, 97 Misc. 2d at 101-02; *Baker v. Com*., 2007 WL 3037718, at *32.

It would be odd to deny CAPA's procedural protections to rules governing hundreds of thousands of retired public employees and their dependents on the theory that this is just "internal" agency business or that the retirees and their dependents are somehow agency "personnel" and not

[30] The City's reliance on the Charter Revision Report is similarly misplaced. *See* City Br. at 49-50. The Report states that the § 1041(5)(b) exception applies to "an agency's resource allocation, work force deployment, purely internal procedures and city employment-related matters." City Ex. 7, Charter Revision Report at 86-87. These categories do not relate to retirees, much less to their dependents or to those who never worked for the agency in question (OLR).

members of the public. Retirement policies typically involve long-settled expectations, and, unlike routine employment decisions made while a public employee is on the job and afforded various other procedural protections, attempted changes to such longstanding policies will often occur, as here, well after the retiree's separation from government service and when the retiree is far removed from any collective bargaining or civil service protections. *See* City Ex. 7, Charter Revision Report at 86-87 (providing as a rationale for the § 1041(5)(b) exception that internal management and personnel decisions are "also often subject to collectively bargained provisions" and "other detailed regulations"). Indeed, none of the cases cited by the City involves retirees. It would be flatly inconsistent with the legislative goal of a "generously" robust CAPA that "give[s] the citizenry a voice in the operation of government" to deny CAPA's protections to hundreds of thousands of elderly and disabled Retirees and their dependents, who deserve no less a voice than other citizens, particularly when it comes to their healthcare. *1700 York Assocs. v. Kaske*l, 182 Misc. 2d 586, 595 (Civ. Ct. N.Y. Cty. 1999).

VII. PETITIONERS ARE LIKELY TO SUCCEED ON THEIR CLAIM THAT RETIREES CANNOT MAKE AN INFORMED OPT-OUT DECISION

Lacking anything substantive to say in response to the missing and inaccurate information about the Aetna MAP, the City simply directs the Court to Aetna's argument on this count. *See* City Br. at 32 (adopting and incorporating Aetna's argument at Section II(a)(2) (pp.15-17) of its brief). Aetna's argument, however, is just a page-and-a-half of conclusory denials combined with statistics about the number of Retirees who attended informational seminars (only 44,252 out of 250,000 Retirees attended) and their satisfaction with those seminars (most attendees were apparently satisfied).

Aetna does not, and cannot, dispute that a substantial number of Retirees never received the informational packages it was supposed to send them. Nor does it dispute that elderly Retirees

who did not receive these packages and who are not computer-savvy cannot make an informed opt-out decision. Thus, it is undisputed that at least some number of Retirees are flying blind when it comes to a monumental decision about their healthcare future.

Nor does Aetna dispute that a substantial number of medical providers do not yet know if they will accept the Aetna MAP and will not make a decision before the July 10 opt-out deadline. Retirees who see such providers likewise cannot make an informed opt-out decision.

Further, neither the City nor Aetna has any response whatsoever to the mass confusion they have created regarding whether and how Retirees who want to maintain Medicare plus supplemental insurance are supposed to opt-out of the Aetna MAP, waive coverage, or both. This issue is discussed at length in Petitioners' opening brief and in the Petition. Petrs.' Op. Br. at 55-56; Pet. at ¶¶ 218-226. Yet in their briefs, the City and Aetna have nothing to say on the subject, thereby conceding the issue.

With respect to Aetna's misleading representation that Retirees can all keep their doctors, Aetna argues in conclusory fashion that this claim is not misleading and that Petitioners' allegation to the contrary is "erroneous." Aetna Br. at 16-17. However, the undisputed evidence in the record—including unrebutted sworn testimony from approximately 350 Retirees, former City officials, and experts—is that doctors, hospitals, and continuing care facilities are consistently reporting that they will not accept the Aetna MAP. *See* NYSCEF Nos. 5-6, 29-43, 52-57. Although it is technically true that these providers must treat Retirees "in emergency situations," Gardener Aff., Ex. D at Ch. 3 § 2.3, they need not, and many have said they will not, accept the Aetna MAP in non-emergency situations. Thus, it is misleading to suggest that Retirees can all keep their doctors. Moreover, even if out-of-network providers agree to see Retirees enrolled in the Aetna MAP, they can (and many likely will) bill Retirees directly. And Retirees who receive

treatment that Aetna retrospectively deems to be unnecessary will have to pay for that treatment themselves. Therefore, many Retirees with out-of-network doctors who cannot afford to pay for their own medical care cannot realistically continue to see these doctors. Retirees cannot make an informed opt-out decision when the informational packages they have received fail to properly warn them about these risks.

Nor can Retirees make an informed opt-out decision when the informational packages do not truthfully explain the differences between the Aetna MAP and traditional Medicare and do not truthfully explain the dangers of prior authorization, a process that is unfamiliar to Retirees, who are used to traditional Medicare. *See* Petrs.' Op. Br. at 54-55.

Aetna relies on the supposed fact that 44,252 Retirees have attended seminars regarding the Aetna MAP and that most attendees who filled out questionnaires reported some level of satisfaction. Aetna Br. at 16. However, the fact that roughly 18% of Retirees have attended an Aetna informational seminar and were satisfied with it is meaningless. First, because Aetna does not reveal the content of its seminars, one can assume that Aetna simply repeated the misleading talking points from its informational packages. Second, even if Aetna somehow dispelled all of the misinformation at these seminars, that would not help the 82% (or roughly 206,000 Retirees) who were not in attendance.

In conclusion, neither the City nor Aetna refutes the numerous ways in which Retirees are presently unequipped to make an informed opt-out decision. Unless and until all Retirees are provided complete and accurate information about the Aetna MAP, the providers who will accept it, and how to avoid being enrolled in it, they should not be forced to decide whether to opt out. A wrong decision may have catastrophic consequences.

VIII. THE CITY HAS EFFECTIVELY CONCEDED IRREPARABLE HARM

"Irreparable harm is the single most important prerequisite for the issuance of a preliminary injunction." *Bank of Am., N.A. v. PSW NYC LLC*, 29 Misc.3d 1216(A), at *10 (Sup. Ct. N.Y. Cty. 2010). Yet the City offers a total of four sentences on the subject. City Br. at 56-57. And these four sentences consist entirely of conclusory statements without citation to any caselaw or evidence. Specifically, the City writes:

> Petitioners' claims of irreparable harm fail for the same reasons as their substantive claims. While Petitioners go to great lengths to paint the Aetna MAP as an inferior health insurance plan that will fail to provide them with adequate coverage, these allegations are not borne out by the facts. As more fully set forth above, the Aetna MAP is a comprehensive, high-quality insurance plan that was designed specifically for New York City retirees and selected through a rigorous procurement process. In short, Petitioners will not suffer irreparable harm absent a preliminary injunction because they will continue to receive premium-free, comprehensive health care coverage that they currently enjoy.

Id. By submitting this staggering non-response to Petitioners' detailed showing of irreparable harm, the City has effectively waived and forfeited any argument to the contrary. *See Levine v. Lawrence*, 2005 WL 1412143, at *5 (E.D.N.Y. June 15, 2005) ("[T]he failure to adequately brief an argument constitutes waiver of that argument[.]").

The threat of irreparable harm in this case is undeniable (which may explain why the City does not seriously deny it), and it necessities immediate injunctive relief. In fact, Aetna argued in 2021 that if Retirees were forced into the Alliance MAP—which the City claimed at the time was better than Aetna's MAP—"the retirees will be irreparably harmed."[31] Here, the harm is even greater, not only because Retirees will be forced into a plan administered by Aetna (the runner-up to the Alliance in the procurement process), but because, unlike in the original MAP lawsuit where

[31] *Aetna Life Insurance Company v. Renee Campion et al.*, Index No. 158216/2021 (Sup. Ct. N.Y. Cty.), NYSCEF No. 16 at 6.

Retirees had the option of maintaining Medicare plus supplemental insurance, Retirees will no longer have access to such insurance.

Lastly, it is important to note that, during briefing on the instant motion, the New York City Comptroller took the extraordinary—and virtually unprecedented—step of refusing, on substantive grounds, to register the Aetna MAP contract.[32] In a statement issued on June 8, 2023, the Comptroller "question[ed] the legality" of the Aetna MAP and expressed "serious[] concern[] about the privatization of Medicare plans, overbilling by insurance companies, and barriers to care under Medicare Advantage."[33] He added, "Recent investigations identified extensive allegations of fraud, abuse, overbilling, and denials of medically necessary care at 9 of the top 10 Medicare Advantage plans, including CVS Health, which owns Aetna."[34]

IX. THE EQUITIES FAVOR RETIREES

The City does not, and cannot, refute the caselaw cited by Petitioners holding that potential threats to the health and well-being of vulnerable individuals outweigh financial or administrative harm to the government. *See* Petrs.' Op. Br. at 67-68.[35] Thus, the City's complaints about the inconvenience of having to delay implementation of the Aetna MAP cannot defeat Petitioners' preliminary injunction motion. *See* City Br. at 57-58. That is especially true given that a

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[32] *Comptroller Lander Declines to Register Medicare Advantage Contract Pending Litigation*, June 8, 2023, https://comptroller.nyc.gov/newsroom/comptroller-lander-declines-to-register-medicare-advantage-contract-pending-litigation/#:~:text=New%20York%2C%20NY%20%E2%80%93%20The%20Comptroller's,enter%20into%20such%20an%20agreement.

[33] *Id*.

[34] *Id*.

[35] The City cites only one case, *Gulf & W. Corp. v. N.Y. Times Co.*, 81 A.D.2d 772 (1st Dep't 1981), regarding balance of the equities. That case involves printing rights asserted by a massive media company where there was no threat of irreparable harm. It has no relevance to the present action.

preliminary injunction would merely require the City—which, it is undisputed, is sitting on a historic multi-billion-dollar surplus, *see* Petrs.' Op. Br. at 67 n.67—to temporarily continue a policy that has existed uninterrupted for nearly 60 years, while the denial of such relief could ruin (financially and medically) countless Retirees.

Perversely, the City contends that granting injunctive relief "would cause further confusion for retirees who have been subject to a near-constant stream of changing information over the past two years." City Br. at 58. The City fails to mention that it is the one to blame for that "near-constant stream of changing information." Regardless, letting Retirees keep their existing health insurance while this case proceeds will in no way cause confusion, and will certainly not cause harm.

Finally, the City argues that a preliminary injunction would be unfair to "the many retirees who do not object to the Aetna MAP and would prefer to have this issue put to rest." City Br. at 58. Petitioners are not aware of a single Retiree who fits that description, nor does the City identify any. But if the City feels that Retirees are eager to enroll in the Aetna MAP, there is nothing stopping it from offering that plan now and letting Retirees voluntarily enroll in it. Of course, the City will not do so because it knows that Retirees will not voluntarily enroll, which further proves that the plan is not an "improve[ment] upon the Senior Care plan," as the City claims. City Br. at 22.

X. IT WOULD BE PREMATURE TO DISMISS PETITIONERS' CLAIMS AT THIS TIME

The City asks this Court to deny the Petition and dispose of the entire case. Even if that request had merit (which it does not), it is premature at this stage.

First, Petitioners have brought a hybrid Article 78 proceeding and plenary action. Their plenary claims cannot be dismissed without dispositive motion practice. Thus, because the City has not moved to dismiss these claims, they cannot be resolved at this time.

Second, as the Court reaffirmed at the June 16 conference, the purpose of the instant briefing is to address Petitioners' preliminary injunction motion. Therefore, Petitioners focus on that motion in this reply brief and reserve the right to address the Petition more broadly after resolution of the motion.

However, because the City has answered the Petition and submitted its evidence in opposition, if the Court were to find that Petitioners have demonstrated success on the six claims addressed above, it could grant the Petition now with respect to those claims.

XI. IT IS UNNECESSARY, AND WOULD BE IMPROPER, FOR THIRD PARTIES TO INTERVENE IN PETITIONERS' LAWSUIT AGAINST THE CITY

Both the MLC and Aetna have moved for leave to intervene in this case as Respondents-Defendants despite the fact that (i) neither faces any potential liability and (ii) the City is perfectly capable of defending its decision to strip Retirees of their longstanding Medicare benefits. In the alternative, the MLC and Aetna ask to be granted *amicus curiae* status. Petitioners object to the MLC and Aetna's intervention, but do not object to their participation as *amici*. *Amicus curiae* status will provide the MLC and Aetna all of the benefits and protections they seek.

In the Retirees' original Medicare Advantage lawsuit, brought in 2021, this Court allowed the MLC and the insurance "Alliance" that would have administered the original MAP to participate as *amici* but not as intervenors. This Court should follow that same sensible approach here. The intervention analysis has not changed, and the Court's previous reasoning applies with equal force to this litigation. Indeed, neither the MLC nor Aetna are entitled to intervention under CPLR 1012 or 1013: the City's ability to defend its implementation of the Aetna MAP is not

"inadequate," and only the City will be "bound by the judgment" (both of these facts independently defeat intervention under CPLR 1012); and neither the MLC nor Aetna have any "claim or defense" relating to this litigation (which defeats intervention under CPLR 1013). *See Reif v. Nagy*, 149 A.D.3d 532, 533-34 (1st Dep't 2017) (denying insurer's motion to intervene under CPLR 1012 and 1013 because its interest was "derivative" of defendant's and because "its position [wa]s well protected" by defendant, "with whom its interests [we]re aligned").

In the Court's order denying the MLC's previous motion to intervene, it stated: "The Court finds that allowing this entity to intervene is not appropriate, as the current [City] respondents are more than capable of articulating the position of why the awarding of the retirees' health insurance went to the Alliance." *NYC Org. of Pub. Serv. Retirees, Inc. v. Campion*, 2021 WL 4920705, at *1 (Sup. Ct. N.Y. Cty. Oct. 21, 2021). Instead, the Court permitted both the MLC and the insurance Alliance "to have the position of *amicus curiae* during th[e] litigation," thereby allowing "the documents they . . . submitted to [be] considered" and their counsel "to speak at . . . oral argument." *Id*. This approach worked well and enabled these entities to be heard without cluttering the proceedings—or burdening the Court and Petitioners—with unnecessary, and improper, parties.

Accordingly, Petitioners respectfully request that the Court follow the same approach here and grant the MLC and Aetna *amicus curiae* status only.[36]

[36] For a more detailed treatment of this issue, Petitioners respectfully rely on the arguments made in the brief opposing intervention in the 2021 lawsuit. *See Campion*, No. 158815/2021, NYSCEF No. 83.

CONCLUSION

For the foregoing reasons and those stated in Petitioners' opening brief, this Court should grant Petitioners' preliminary injunction motion.[37]

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[37] If the Court were to grant the motion, Petitioners respectfully request that it do so based on all of the claims for which it finds a likelihood of success on the merits, as opposed to just one. That would allow a comprehensive review on appeal, if and when the City were to appeal.