To be argued by:
RICHARD DEARING
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New York Supreme Court
Appellate Division: First Department

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

Plaintiffs-Respondents-Appellants,

against

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

Defendants-Appellants-Respondents.

Case No. 2022-01006

BRIEF FOR APPELLANTS-RESPONDENTS

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PRELIMINARY STATEMENT

In this article 78 proceeding, six municipal retirees and a corporation formed for litigation purposes challenge the City of New York's plan to roll out a new and better cost-free healthcare plan for Medicare-eligible retirees. Supreme Court, New York County (Frank, J.) rejected petitioners' primary contentions, dismissing their claims that the City cannot alter healthcare arrangements for existing retirees, as well as their challenges to the rationality and implementation of the change in plans.

But the court nonetheless granted the petition in part, adopting petitioners' novel and mistaken position that Administrative Code § 12-126 obligates the City not just to provide a cost-free healthcare plan, but also to pay for *other* healthcare plans. Under Supreme Court's implausible view, the City would satisfy the provision if it were to take the drastic step of making its new plan the exclusive one for Medicare-eligible retirees and cancelling all optional, more expensive plans, but since the City intends to give people a choice to opt out of the new cost-free plan and enroll in other plans at their election, it must pay for those other plans too.

This Court should vacate Supreme Court's order and deny the petition in its entirety. Section 12-126's command is narrow: the City must make one cost-free healthcare plan available to employees, retirees, and their dependents—with the City's monetary obligation capped at a level tied to the relevant category of insurance provided. And the City will satisfy this command as to the only category at issue here, Medicare-eligible individuals, by making its new plan available to them at zero cost. Nothing in § 12-126 gives petitioners the right to a particular healthcare plan. Nor does it obligate the City to cover the premium when they make the personal decision to decline the free plan in favor of a more expensive plan—any more so than when an employee declines the free plan to be a dependent on a partner's plan from another employer.

Supreme Court thus misread Administrative Code § 12-126 in two ways, each of which independently requires reversal. First, the City's provision of the new plan for free to Medicare-eligible retirees will satisfy its obligation under § 12-126; giving retirees the additional option of paying for other plans does nothing to change that fact. Second, and in any event, the Court misunderstood § 12-126's

monetary cap on the City's payment obligation in a way that ignores key features of the law's text and history, as well as basic realities of health insurance coverage.

The stakes are considerable. While it is understandable that petitioners would prefer to keep their current healthcare plan at zero cost to them, the law affords them no legal entitlement to do so. Meanwhile, the City faces profound fiscal challenges on multiple fronts. The costs of retiree healthcare alone have tripled over the past two decades, approaching $1 billion annually. The situation is unsustainable and, left unchecked, potentially disastrous.

That is why municipal unions worked hand in hand with the City for years to shape a new healthcare plan that would not just maintain, but improve, the quality of care available to Medicare-eligible retirees, while realizing hundreds of millions of dollars in cost savings annually by tapping into available federal subsidies more fully than before. Supreme Court's flawed reading of the Administrative Code threatens to disrupt the City's carefully crafted and fiscally prudent approach. The Court should vacate that ruling and order the petition dismissed in full.

QUESTION PRESENTED

Did Supreme Court err in holding that Administrative Code § 12-126 prohibits the City from rolling out a new cost-free healthcare plan for Medicare-eligible retirees unless it either (a) cancels all other optional, more expensive plans currently available to such individuals, or (b) subsidizes those other plans?

STATEMENT OF THE CASE

Petitioners brought this proceeding to stop the City from transitioning from one cost-free healthcare plan for Medicare-eligible retirees (Senior Care) to another (the Medicare Advantage Plus Plan). The court below held that the City could undertake the transition, but only by either (a) cancelling all the more expensive, optional plans that are now available to Medicare-eligible retirees, or (b) subsidizing those plans.

That ruling was based on a mistaken understanding of Administrative Code § 12-126. Here, we outline the evolution of that local law, along with the City's healthcare offerings over time. This includes the sea change caused by the introduction of Medicare and the federal government's assumption of the role as the primary in-

surer for people age 65 or older, with employers like the City offering supplemental plans sometimes referred to as "Medigap" plans. And because the story of the City's healthcare offerings is about more than the legal floor established by § 12-126, we also describe how the City has often chosen to go further than the Administrative Code requires by entering into agreements with municipal unions to cover additional healthcare costs.

A. The City's historic commitment to providing robust healthcare coverage to its employees, retirees, and their dependents

1. The City's healthcare offerings before the introduction of Medicare

Going back nearly 80 years, long before Administrative Code § 12-126 existed, the City has provided high-quality healthcare coverage to its public servants. Starting in 1946, the City decided to provide employees and their families with access to "the most complete and the best medical care and attention possible" (Record on Appeal ("R") 1376). After extensive study, the City found that "the most comprehensive and complete" coverage was offered by the Health Insurance Plan of Greater New York (HIP), then a nonprofit

membership corporation (R1357–76). The City and employees shared the costs of HIP coverage (R1376–77). Hospitalization insurance was also provided through Blue Cross (R1350, R1365–66).

In 1965, the City agreed to "provide a choice of health insurance plans for certain employees in the uniformed forces" (R1342, R1350–51). After a transition period, the City assumed 100% of the cost, not to exceed "the full cost of HIP-Blue Cross (21-day Plan) on a category basis" (R1350). By the end of that year, the City extended those benefits to other municipal employees (R1341–48). And retirees could choose among "the same, or equivalent" plans offered to employees, with the City paying for "such choice," though with the cost "not to exceed 100% of the full cost of H.I.P.-Blue Cross (21-day Plan) on a category basis" (R1343–45). In recognition of differences in the healthcare needs of employees and those of retirees generally, the City specifically allowed providers to charge different premiums for those two categories (R1344–45).

2. The City's early response to the introduction of Medicare as the primary insurer of people age 65 and older

Medicare's enactment in 1965—and the federal healthcare benefits it provided to those 65 and older—sparked fundamental changes in health insurance programs across the country. The City was no exception.

That same year, the City commissioned a study to examine "the effect of the [M]edicare program" on the City's offerings and to recommend "adjustments or revisions" to "further the health and welfare of the City's employees and retirees, and protect the interests of the City" (R1347).

Once Medicare went into effect in 1966, the City's healthcare plans for individuals eligible for Medicare took on a new form (R1339). On the most basic level, they dropped benefits that duplicated Medicare and offered only coverage that supplemented Medicare—transforming into what would come to be known as "Medigap" plans (R1339).

By mayoral order, the City at the time also assumed responsibility for paying the premiums for Medicare Part B for active employees (R1339).[1] To do the same for retirees, however, required amending local law (R1337–39).

B. The evolution of Administrative Code § 12-126 and the floor it sets for healthcare coverage

1. The failed proposal to compel the City to pay for any basic healthcare plan

Legislators responded to the changing backdrop. In 1967, the City Council began debating the scope of the City's obligation to cover healthcare costs for its active and retired workforce.[2] The Council's first attempt proved too expansive. As proposed, that bill

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[1] Medicare Part B premiums pay for medical insurance for services from doctors, outpatient care, durable medical equipment, and many preventive services. *See Part B Costs*, U.S. Ctrs. for Medicare and Medicaid Servs., https://perma.cc/8XRL-GA7G (last visited Mar. 20, 2022). By contrast, Medicare Part A provides hospital insurance and is generally premium-free. *See Part A Costs*, U.S. Ctrs. for Medicare and Medicaid Servs., https://perma.cc/ZMX5-AXF7 (last visited Mar. 20, 2022).

[2] In the Administrative Code, the "cost" of coverage refers to the cost of premiums. Indeed, the Administrative Code's legislative history makes clear "that the drafters … considered 'cost' to be the equivalent of 'premium.'" *N.Y. 10-13 Ass'n v. City of N.Y.*, 1999 U.S. Dist. LEXIS 3733, *35–38 (S.D.N.Y. Mar. 29, 1999). Thus, the Administrative Code obligates the City to pay the premium cost but not other out-of-pocket expenses, such as deductibles. Petitioners have not argued otherwise.

would have required the City to "pay for the entire cost of *any* basic health insurance plan" for essentially all employees, retirees, and their dependents (R1324 (emphasis added)).

Then-Mayor John Lindsay vetoed the bill. Among his concerns was the risk that the law "expos[ed] the City to unforeseeable and possibly unwelcome additional demands on its financial resources" (R1326). Specifically, Mayor Lindsay objected to requiring the City to pay "the entire cost of any basic health insurance plan" because "the City would be bound to an open-ended obligation to pay for coverages which it cannot now possibly anticipate" (R1326).

2. Local Law 120 of 1967 and the obligation to provide a cost-free healthcare plan, with a category-based monetary cap

Local Law 120 of 1967 addressed many of these problems. The law jettisoned the obligation to pay for "any basic health insurance plan" in favor of requiring the City to cover "the entire cost of Health Insurance Coverage for City employees, City retirees, and their dependents" (R1320–21, 1331–32). "Health Insurance Coverage" was defined in the singular as: "*A* program of hospital-surgical-

medical benefits to be provided by health and hospitalization insurance contracts entered into between the city of New York and companies providing such health and hospitalization insurance" (R1320, 1332 (emphasis added)).

Limiting the City's financial obligation, the law capped the amount that the City was required to pay to obtain a full "program of hospital-surgical-medical benefits" (R1320–21, 1333–35). Under the law, the City was obliged to pay no more than "one hundred per cent of the full cost of H.I.P.-Blue Cross (21-day plan) on a category basis" (R1321, 1335). As explained, HIP-Blue Cross had been around since 1965, though by this point the plan was really two different plans: it differed significantly for Medicare-eligible individuals as compared with those who were not eligible for Medicare—for the former, the coverage was only a secondary "Medigap" plan supplementing Medicare (R1338–39).

The law also recognized other differences between Medicare-eligible individuals and everyone else. To adapt to Medicare, the law prescribed additional requirements "[w]here such health insur-

ance coverage is predicated on the insured's enrollment in [Medicare]" (R1320–21). For those Medicare enrollees, the City was required to reimburse the Medicare Part B premiums they paid to the federal government (R1321), in addition to providing supplemental coverage at no cost.[3]

The law also omitted language that would have limited the City's flexibility in selecting a healthcare plan. Unlike the City's then-existing agreements with municipal unions, the law did not require the City to pay for a "choice of health and hospital insurance" (R1350–51, 1342–45). And the City Council considered *and rejected* a proposal that would have prohibited the City from reducing benefits in the future (R1320–21, 1331–35).

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[3] The law initially identified the specific amount of Medicare Part B premiums, requiring the City Council to amend the law to correspond with any federal increases (R1138). Eventually, the Council committed to cover all such premiums regardless of amount (R1138). Code § 12-126(b)(1) ("the City shall reimburse covered employees in an amount equal to one hundred percent of the Medicare Part-B premium rate applicable to that year").

3. Local Law 28 of 1984 and the updated category-based monetary cap

By 1984, the HIP product that the local law referenced for its category-based monetary cap—HIP-Blue Cross—had been discontinued and replaced by a new HMO plan—HIP/HMO (R1141–43, 1408–11, 1414).[4] But like its predecessor, HIP/HMO was really two different plans. For employees and retirees under age 65, the plan provided "primary health insurance coverage" (R1414–17). For those age 65 or over, Medicare provided the "first level of benefits," with the HMO covering *only* "certain gaps in Medicare coverage" (R1414). Because HIP's HMO "d[id] not duplicate benefits which [were] available under Medicare," Medicare-eligible enrollees had to "maintain Medicare Part B coverage or lose their HIP/HMO membership" (R1414).

Local Law 28 of 1984 addressed this changed landscape, amending Administrative Code § 12-126 to update the category-

[4] An HMO, or Health Maintenance Organization, is a managed care insurance plan through which a primary care physician manages each member's healthcare needs and typically requires the use of network doctors and facilities (R111). By contrast, a PPO, or participating provider organization, typically offers the freedom to use either a network or out-of-network provider (R111).

based monetary cap accordingly. Under the revised law, the City would "pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P-H.M.O. on a category basis"—that is, based on the category of coverage provided, such as whether it is Medigap coverage or primary insurance coverage (R1134).

Corresponding HIP HMO plans are still available today through HIP's successor, EmblemHealth, though the labels have changed.[5] Like their predecessors, these contemporary HIP offerings continue to recognize the fundamental difference between people who are eligible for Medicare and those who are not. The HIP HMO for people under age 65 is HIP HMO Preferred, and because it covers people who are not eligible for Medicare, it serves as the "primary insurer" (R106, 133, 1282–83). In 2021, the premiums for individuals were around $776 per month, and covered by the City (R133, 1282–83, 1293).

[5] In 2006, HIP and GHI merged to form EmblemHealth, which is also one of the providers slated to offer the new Medicare Advantage Plus Plan.

Meanwhile, the current HMO for Medicare-eligible retirees is VIP Premier (HMO) Medicare, also known as HIP VIP Medicare ("HIP VIP HMO") (R148, 157, 1282–83). The 2021 premiums for enrollees in HIP VIP HMO were approximately $182 per month—less than a quarter of the cost for HIP HMO Preferred (R1282–83, 1293–94). Those premiums were likewise covered by the City, along with Medicare Part B premiums (R1281–83, 1293–94).

C. The City's agreements with municipal unions to provide coverage above and beyond what is required by Administrative Code § 12-126

Administrative Code § 12-126 identifies a floor, not a ceiling, for the healthcare coverage offered to City employees, retirees, and their dependents. While the local law uses HIP's HMO products to create a category-based monetary cap on the City's mandatory financial obligation (R1134), the City has often agreed through collective bargaining to exceed the cap.

In 2021, for example, the City's agreement with the MLC designated Senior Care as a premium-free plan for Medicare-eligible retirees (R1282–83, 1294; NYSCEF No. 61 at 3–5). Senior Care is jointly administered by GHI and Empire BlueCross BlueShield

(R151).[6] As a "Medigap" plan, Senior Care supplements, rather than duplicates, Medicare benefits (R102–03, 111, 148, 151, 1282–83; NYSCEF No. 77 at 4).

The premiums for Senior Care reflect Medicare's primary role and the plan's supplemental coverage. Thus, in 2021, monthly premiums for Medicare-eligible retirees were approximately $192, which exceeded HIP VIP HMO's premiums for that year by roughly $10 per month and which the City agreed to cover in full (R1282–83, 1293–94). By contrast, monthly premiums for the counterpart GHI/Empire product available to those ineligible for Medicare were about $776—or roughly four times higher—because, as with HIP HMO Preferred, for that category (under-65s) the plan operates as the primary insurer (R106, 113, 126, 1293).

Senior Care has been the most popular plan for Medicare-eligible retirees, with roughly 200,000 enrollees out of the City's approximately 250,000 retirees (R892). Nevertheless, out-of-pocket expenses have risen over the years: in 2021, Senior Care charged

[6] GHI provides medical insurance and Empire provides hospitalization insurance.

participants a $50 medical benefit deductible and a $300 hospital inpatient deductible (NYSCEF No. 61 at 5). Participants were also responsible for certain copays and other Medicare deductibles before Senior Care coverage kicked in (R102, 151, 885–86).

By operation of the City's agreement with municipal unions, retirees who do not select Senior Care or a HIP HMO are required to pay only premiums that exceed the cost of those plans (R1282–83, 1293–94; NYSCEF No. 61 at 3–5). For 2022, the total premium for these more expensive plans, including the City's contribution, ranged from roughly $263 for United Healthcare Group Medicare Advantage Plan Horizons (NJ) to $789 for GHI HMO Medicare Senior Supplement.[7]

Over time, rising healthcare costs pushed the City and the MLC to examine "savings and efficiencies in the method of health care delivery," including taking advantage of substantial federal subsidies available through Medicare, to preserve the "longer term sustainability of health care for workers and their families"

[7] These premium rates are for individual coverage; family coverage premiums are higher (R1293). *See, e.g.*, N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of Jan. 1, 2022* (2021), *available at* https://perma.cc/HFM8-8463.

(NYSCEF No. 61 at 6–8). Skyrocketing healthcare costs are a nationwide phenomenon; even before the COVID-19 pandemic, national healthcare spending was expected to easily outpace gross domestic product and reach $6.2 trillion by 2028.[8]

Medicare Part B premiums have also more than tripled in the past 20 years, with a 14.5% increase in the last year alone.[9] Overall, the City's Part B reimbursement costs have risen sevenfold over a similar 20-year period—from $54 million in 2000 to $382 million in 2020 (NYSCEF No. 118 at 16). Despite these trends, both the City and the MLC agreed that any adjustments to the City's healthcare offerings should "maintain and improve upon existing retiree benefits while at the same time reducing cost" (NYSCEF No. 61 at 8; *see* R884, 908–09; NYSCEF No. 118 at 17).

The City and the MLC carefully evaluated possible adjustments. At first, their focus was on plans for people ineligible for Medicare, largely active employees (R909; NYSCEF No. 61 at 7–8).

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[8] *NHE Fact Sheet*, U.S. Ctrs. for Medicare & Medicaid Servs., https://perma.cc/UD9H-QWPU (last visited Mar. 20, 2022).

[9] Tricia Neuman et al., *Monthly Part B Premiums and Annual Percentage Increases*, Kaiser Family Foundation (Jan. 12, 2022), https://perma.cc/3QYA-NG3J.

The previous two agreements between the City and the MLC made significant changes to plans for those workers, including increased copays in multiple areas (R909; NYSCEF No. 61 at 7–8). For many years, no changes were made to the retiree plans, although costs were rapidly increasing in that area as well (R909). By 2020, however, the City and the MLC concluded that providing a Medicare Advantage plan to Medicare-eligible retirees would realize substantial savings by "taking advantage of federal funding" (NYSCEF No. 61 at 8; *see* R909), while providing "equivalent or better benefits" (NYSCEF No. 118 at 17; *see* R884–90, 908–09). And so, the City and the MLC agreed to replace Senior Care with a new Medicare Advantage plan as the premium-free offering for Medicare-eligible retirees (NYSCEF No. 61 at 3–11).

To select a provider for the new plan, the MLC and the City embarked upon a nine-month process, with a joint committee closely examining multiple proposals (NYSCEF No. 61 at 8–9; NYSCEF No. 118 at 16–17). Eventually, the committee recommended the Medicare Advantage Plus Plan (MAPP), a custom-built

plan for City retirees age 65 or over that would be jointly administered by the Alliance—a partnership between Empire BlueCross BlueShield and EmblemHealth (R884, 892; NYSCEF No. 61 at 2–3, 8–9).[10] The MLC's member unions "voted overwhelmingly in favor" of the plan (NYSCEF No. 61 at 8–9; *see* R907–09). Meanwhile, Senior Care, although no longer free, would remain available to those who wished to pay the 2022 monthly premium of about $192 (R885, 1300; NYSCEF No. 118 at 19).

Determined to avoid reducing benefits, the City and the MLC ensured that MAPP would be equivalent to or better than Senior Care (R883–909; NYSCEF No. 61 at 11; NYSCEF No. 118 at 17). Indeed, both plans would be administered by the same entities—EmblemHealth and Empire (R892). Copays were either the same or lower with MAPP and, much like Senior Care, retirees could visit any doctor nationwide who accepted Medicare (R884–93). Because

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[10] Supreme Court (Frank, J.) denied article 78 petitions from two other insurance companies, Aetna and United Healthcare, challenging the Alliance's selection. *Aetna Life Ins. Co. v. Campion*, Index No. 158216/2021 (N.Y. Sup. Ct. Oct. 21, 2021); *United Healthcare Servs., Inc. v. Campion*, Index No. 158757/2021 (N.Y. Sup. Ct. Oct. 21, 2021). The court described the selection of the Alliance as "a boon to the City" and the selection process as "not only rational, but wise." *Aetna*, Index No. 158216/2021, slip op. at 5–6.

MAPP also took full advantage of untapped federal Medicare funding, these enhanced benefits were available despite realizing *$600 million* in annual savings (R907–09; NYSCEF No. 118 at 15–16). Every dime saved would go to the Health Insurance Stabilization Fund, which the City and the MLC jointly administer to ensure funding for the City's full suite of health insurance offerings, including benefits for chemotherapy, specialty drugs, preventative care, welfare benefit funds for employees and retirees, as well as a fund for widows and orphans (R1281–85, 1298; NYSCEF No. 118 at 15–16).

These savings were available only through MAPP because of the Medicare Advantage program, which pays private insurers directly to provide health insurance.[11] Not only are these privately administered plans typically more efficient, but the federal subsidies provided for Medicare Advantage plans are often greater than payments made under traditional Medicare, thus allowing Medi-

[11] *How Do Medicare Advantage Plans Work?*, U.S. Ctrs. for Medicaid and Medicare Servs., https://perma.cc/DJU8-SGJ5 (last visited Mar. 20, 2022).

care Advantage plans to offer significantly enhanced benefits at reduced cost to enrollees (NYSCEF No. 118 at 15).[12] Seeking to gain access to these increased federal funds and superior efficiencies while also maintaining benefits, the City and the MLC leveraged their joint bargaining power to customize a plan to provide "the same comprehensive coverage [as Senior Care] in the context of a Medicare Advantage structure and add[] certain additional benefits not available under Senior Care" (R907–09).

Indeed, even while achieving dramatic savings, MAPP's coverage will surpass Senior Care's in many respects. For example, unlike Senior Care, MAPP caps annual participant out-of-pocket expenses at $1,470, does not require coinsurance for hospital stays, and includes unlimited durable medical equipment benefits (R884–90, 908–09). MAPP also provides 24-hour nonemergency transportation to doctors and pharmacies, a fitness membership, and meal delivery following hospitalization (R884–90, 908–09). And MAPP

[12] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* 414–20 (2022), *available at* https://perma.cc/GV7P-JRKQ.

permits lower deductibles than Senior Care, resulting in more savings for participants (NYSCEF No. 61 at 5).

MAPP also requires preauthorization for certain services to ensure that retirees receive the most effective care and are not surprised by a post-treatment determination that they will have to foot the bill (R886, 893–95; NYSCEF No. 61 at 11; NYSCEF No. 118 at 19). Preauthorization is limited to only those services where prior review would most likely benefit the insured, and no claim is denied without a physician's review (R886, 893–95). Although petitioners expressed concern that this protocol delays treatment, federal and state laws mandate strict processing timeframes, and preauthorization is not required in emergencies (R886, R893–95; *see* NYSCEF No. 118 at 19). MAPP's preauthorization rules are also nearly identical to the requirements for active employee plans, and most retirees are therefore familiar with the process based on the plans in which they were enrolled before reaching Medicare eligibility (R886; NYSCEF No. 118 at 19).

The plan to roll out MAPP has also led other healthcare plans to reduce premiums. Since MAPP would be cost-free, HIP VIP HMO

made the business decision to lower premiums for 2022 to $7.50 per month, matching the premiums for MAPP, to retain market competitiveness (R1970–71).

D. This misguided challenge to the City's plan to roll out a new and better healthcare offering for Medicare-eligible retirees

Petitioners in this case are a handful of retirees and a corporation created for the purpose of this litigation that, according to the petition, purports to have a "membership" comprising less than 1% of retirees (R26–28, 32–34, 61). After the City announced its plan to roll out MAPP, petitioners brought this article 78 proceeding challenging the plan's implementation and the requirement that retirees pay premiums to remain in Senior Care (R26). In addition to seeking to halt the City and MLC's carefully negotiated agreement to implement MAPP, petitioners argued that Administrative Code § 12-126 requires the City to pay up to $600 per month per person for the healthcare plan of each retiree's choosing, though they failed to identify any source for that figure (R28, 34, 69).

The City moved to dismiss the petition, arguing among other things that § 12-126 only requires it to provide one cost-free option

and caps its financial obligation at "the full cost of H.I.P.-H.M.O. on a category basis" (NYSCEF No. 79 at 6). That duty would be satisfied through MAPP, which would be available to Medicare-eligible retirees at no cost. Nothing in the Administrative Code, the City argued, requires it to pay for other plans. The MLC and the Alliance, for their parts, agreed (NYSCEF Nos. 205, 206).

Petitioners opposed dismissal and made a procedurally improper motion for summary judgment, before the City's motion to dismiss had been decided and before the City had an opportunity to answer the petition (R1127). As to § 12-126, petitioners claimed that the law requires the City to subsidize any plan that Medicare-eligible retirees select, but they upped the price tag to $776 per person per month—corresponding to the premiums for HIP HMO Preferred, a plan available to persons who are ineligible for Medicare (NYSCEF No. 189 at 7). In response, the City and the MLC explained that, even assuming § 12-126 requires the City to pay for multiple plans, the proper cap "on a category basis" would be the premium rate for the HIP HMO actually offered to Medicare-eligible retirees: HIP VIP HMO (R1970–71; NYSCEF No. 205 at 15).

E. Supreme Court's order granting the petition in part after misreading Administrative Code § 12-126 in two different ways

Supreme Court, New York County (Frank, J.), denied the City's motion to dismiss and granted the petition in part, without affording the City an opportunity to answer (R7–10). First, the court rejected petitioners' claims that the City could not offer MAPP as an alternative to Senior Care. As the court explained, the City and the Alliance's outreach to retirees and providers had remedied any issues there may have been with MAPP's implementation, the decision to transition to MAPP was not irrational, and petitioners did not have a constitutional or contractual right to keep their current plan at zero cost (R8).

Yet despite acknowledging that petitioners' motion for summary judgment was improper, the court also permanently enjoined the City "from passing along any costs of the New York City retirees' current plan to the retiree or to any of their dependents, except where such plan rises above the H.I.P.-H.M.O. threshold, as provided by New York City Administrative Code Section 12-126" (R10). According to the court, this provision means that "so long as the

[City] is giving retirees the option of staying in their current program, they may not do so by charging them the $191 the respondent intends to charge" (R8). As the court made clear, its ruling did not require the City to "give retirees an option of plans," but if the City did choose to do so, the court's "understanding" was that "the cost of the retirees' current health insurance plan" did not surpass § 12-126's monetary cap (R9). Accordingly, the City could not "pass any cost of the prior plan to the retirees" (R9).

On March 4, 2022, the City filed a notice of appeal (R3). Eleven days later, petitioners noticed a cross-appeal (R5).

ARGUMENT

SUPREME COURT MISCONSTRUED ADMINISTRATIVE CODE § 12-126 IN TWO DISTINCT WAYS

In two separate respects, Supreme Court misconstrued Administrative Code § 12-126 by ruling that the City must pay premiums for Senior Care and other more expensive plans following MAPP's rollout. Each error independently requires reversal.

First, the City's plan to provide MAPP to Medicare-eligible retirees at no cost to them fully satisfies its obligation under § 12-126.

The law requires the City to provide cost-free healthcare coverage, and MAPP will achieve precisely that. Contrary to Supreme Court's ruling, nothing about the additional plans that the City makes available to retirees can change that conclusion. The court itself acknowledged that § 12-126 does not require the City to offer Medicare-eligible retirees any additional plans beyond MAPP. But it nonetheless held that *if* the City does make additional options available, § 12-126 limits the City's ability to charge those who decline MAPP in favor of those other plans. Neither the law's text nor sound policy supports encumbering the City's and retirees' options in that way.

Second, and in any event, Supreme Court also misidentified the law's monetary cap as applied to the category of Medicare-eligible individuals. By its plain terms, § 12-126 limits the City's payment obligation to coverage whose "entire cost" does not exceed that of "H.I.P.-H.M.O. on a category basis." For the category of Medicare-eligible individuals, the relevant metric is logically the HMO plan issued by HIP that provides coverage for those who are eligible for Medicare—at present, the HIP VIP HMO plan.

There is no basis for Supreme Court's apparent conclusion that the cap on the City's obligations is instead established by the dramatically more expensive cost of HIP's HMO plan for individuals ineligible for Medicare—the HIP HMO Preferred plan. Persons who are not eligible for Medicare fall into a fundamentally different insurance category from persons who are, because the former require stand-alone primary health coverage while the latter require only coverage ancillary to Medicare, which is heavily subsidized by the federal government. The City Council was well aware of this distinction when enacting § 12-126—indeed, the law expressly references it.

A. MAPP satisfies the City's obligation to Medicare-eligible retirees regardless of what other plans the City makes available.

In matters of statutory construction, "[t]he primary consideration … is to ascertain and give effect to the intention of the Legislature." *People v. Santi*, 3 N.Y.3d 234, 243 (2004). The inquiry begins with the statutory text—"the clearest indicator of legislative intent"—and also considers the law's "spirit and purpose," as illuminated by its context and legislative history. *Matter of Albany Law*

School v. N.Y.S. Office of Mental Retardation & Dev. Disabilities, 19 N.Y.3d 106, 120 (2012); *see also Rodriguez v. City of N.Y.*, 31 N.Y.3d 312, 320 (2018) (noting legislative history's relevance even where the text is clear).

Here, all of these sources confirm that providing MAPP to Medicare-eligible retirees at no cost satisfies § 12-126's mandate. The law's text states in relevant part that "[t]he city will pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents." And the City will plainly pay the entire cost of coverage for Medicare-eligible retirees through MAPP, as the City will provide that plan on a premium-free basis. That conclusion is unchanged by the fact that the City also intends to give Medicare-eligible retirees the option of declining MAPP in favor of other plans, for which they must then pay.

Supreme Court mistakenly reasoned that the law's text providing that the City "will pay"—rather than offer to pay—unambiguously dictated its ruling. The phrase "will pay" does not denote a categorical and unconditional obligation that operates irrespec-

tive of individuals' choices. For example, City employees may decline city healthcare coverage altogether, often because they elect to be covered under a partner's insurance. But § 12-126 does not require the City to pay for health coverage for those employees nonetheless. In a similar vein, the law's "will pay" language does not preclude the City from giving retirees (or employees) the option of declining free coverage in favor of a different City-offered plan that they must agree to pay for.

Moreover, several factors decisively undercut Supreme Court's reading of § 12-126. First, the law defines "health insurance coverage" in singular terms, as "[a] program of hospital-surgical-medical benefits." When that definitional language is substituted into the operative sentence, it becomes "[t]he city will pay the entire cost of [a program of hospital-surgical-medical benefits] for city employees, city retirees, and their dependents." Providing MAPP on a premium-free basis plainly meets that requirement, full stop.[13]

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[13] Petitioners argued below that ancillary language later in the definition referring to "contracts" for insurance with "companies," plural, undercuts the City's reliance on the definition's core description of "a program" of insurance, singular (*see, e.g.*, NYSCEF No. 189 at 9–10). But there is no contradiction or

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Second, the law's definition of "health insurance coverage" gains added significance when one considers the law's enactment history. The City Council rejected a prior version of the law that would have required the City to pay for "any basic health insurance plan," after then-Mayor Lindsay vetoed that bill. The City Council thus knew how to draft language that would require the City to pay for any available plan that met certain criteria, yet specifically declined to adopt such language in § 12-126. Supreme Court's approach would thus "read into [the] statute a provision which the Legislature did not see fit to enact." *Chem. Specialties Mfrs. Ass'n v. Jorling*, 85 N.Y.2d 382, 394 (1995) (internal quotation marks omitted).

The City Council also declined other opportunities to incorporate language that would have codified an obligation to pay for retirees' choice of plan. Two years before the adoption of § 12-126, the City had agreed with municipal unions to cover "total payment *for*

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even tension. Single insurance plans commonly involve multiple contracts and, indeed, multiple companies contracting separately to provide different types of benefits. For example, the baseline plan originally referenced in the Administrative Code was the "H.I.P.-Blue Cross (21-day plan)," under which HIP provided medical benefits and Blue Cross provided hospital benefits.

choice of health and hospital insurance" among multiple plans (R1342 (emphasis added)). But § 12-126 pointedly did *not* include such language.

Third, Supreme Court's understanding of the law makes little policy sense. As the court acknowledged, nothing in § 12-126 requires the City to provide more than one insurance plan at all. It is hard to see why the City Council would create a regime that does not require any alternative plans to be offered, but compels the City to pay for them if they are offered, subject only to the law's monetary cap. There is no good reason to eliminate the option of providing below-cap alternatives but requiring those who elect them to pay for them. To the contrary, mandating a subsidy for any below-cap plan that the City offers could result in the City declining to provide options to retirees at all. That would limit retirees' choices overall—to no obvious end.

What is more, the core objective that drives petitioners' argument is one that the City Council rejected for enshrinement in § 12-126. At bottom, petitioners are contending that they are entitled to keep the particular plan of their choice on a cost-free basis because

it was free to them in the past. But the enactment history does not support that claim. An early version of the bill that became § 12-126 included language that would have barred the City from reducing the healthcare benefits it was then offering—at that time, a subsidized choice of plans (R1320, 1332, 1335). That text was stricken from the final bill. A fortiori the City Council did not intend to freeze particular plan arrangements in place. Instead, the Council intended § 12-126 to give the City flexibility to structure healthcare arrangements as policy and budgetary needs dictated, so long as a cost-free plan was provided. For this reason too, the City's construction of § 12-126 is by far the better one.

But even if that were not so, § 12-126 is at the very least ambiguous. In that circumstance, courts are required to "defer to the interpretation of the agency charged with administering the statute," which "must be upheld as long as it is reasonable." *Matter of Chin v. N.Y.C. Bd. of Standards & Appeals*, 97 A.D.3d 485, 487 (1st Dep't 2012); *see also Int'l Union of Painters & Allied Trades, Dist. Council No. 4 v. N.Y.S. Dep't of Labor*, 32 N.Y.3d 198, 209 (2018)

(agency interpretation "entitled to deference unless it is inconsistent with unambiguous language in the statute or irrational"). And because the City's interpretation is at least reasonable, petitioners would still be unable to satisfy their burden of showing that the City's actions were "affected by an error of law." CPLR 7803(3).

B. The monetary cap in § 12-126 separately defeats any obligation to pay for Senior Care or more expensive, optional plans.

Even if § 12-126 were not wholly satisfied by MAPP, which it is, Supreme Court separately erred in ordering the City to pay premiums for other plans that exceed the law's monetary cap. Although the court did not specifically identify the threshold it was applying, at a minimum the court ordered the City to pay premiums for Senior Care, which in 2022 amounted to roughly $192 per month. Petitioners, for their part, argued that § 12-126 requires the City to pay up to $776 per month, corresponding with the premiums for HIP HMO Preferred—a plan that is offered to persons ineligible for Medicare.

Neither is the right lodestar. Section 12-126 directs the City to "pay the entire cost of health insurance coverage for city employees, city retirees, and their dependents, not to exceed one hundred percent of the full cost of H.I.P.-H.M.O on a category basis." The HIP HMO available to Medicare-eligible retirees like petitioners, HIP VIP HMO, costs $7.50 month in 2022, and has nearly always charged lower premiums than Senior Care. As HIP VIP HMO is the only HIP HMO that is available to petitioners "on a category basis" as Medicare-eligible individuals, § 12-126 could require the City to pay for health insurance coverage only where its cost falls below that threshold.

The statute's plain text dictates this understanding. The law explicitly caps the City's obligation at "one hundred percent of the full cost of H.I.P.-H.M.O *on a category basis*." Code § 12-126 (emphasis added). This means that the cap on the City's payment obligation varies by the category of insurance provided. For example, the cap applicable for an employee or retiree who has an individual health insurance plan should not be based on the rate for a family

HIP HMO plan—individual and family plans are different categories. Similarly, the cap applicable to a plan for Medicare-eligible individuals should not be based on the rate for a HIP HMO plan for people ineligible for Medicare—those, too, are different categories.

This understanding is embodied in the very text of § 12-126. The law includes a specific provision requiring the City to pay Medicare Part B premiums when an individual's "health insurance coverage is predicated on the insured's enrollment in the hospital and medical program for the aged and disabled under the Social Security Act"—in other words, Medicare. Thus, the City Council was well aware that certain city-offered insurance plans would provide supplemental coverage predicated on an individual's enrollment in Medicare, and specified that such plans should receive different treatment from plans made available to individuals ineligible for Medicare. By its terms, then, § 12-126 recognizes that coverage for Medicare-eligible individuals falls into its own category.

The same distinction between categories is reflected in the City's longstanding practices. For example, HIP distinguishes between the HMO plan for non-Medicare-eligible individuals—HIP

HMO Preferred—and the HMO plan for Medicare-eligible retirees—HIP VIP HMO. Understandably, the costs of those plans are dramatically different: HIP HMO Preferred provides primary coverage, while HIP VIP HMO provides coverage alongside federally funded Medicare and is thus far less expensive. Other insurers—like GHI, Aetna, CIGNA, and Empire—follow the same approach (R148).[14] Experience shows that plans offering primary insurance are often four or more times costlier than Medicare-based ones.

This same distinction is seen throughout the broader health insurance industry, where providers routinely speak of "Medigap plans" or "Medicare supplemental coverage" or "Medicare wrap-around coverage" and consistently offer such coverage at a fraction of the amount charged for primary coverage. It would not be an ap-

[14] The original statute's use of HIP-Blue Cross as the baseline plan further demonstrates § 12-126's intent to apply different rates for those eligible and those ineligible for Medicare. When the 1967 statute was enacted, it required the City to pay "one hundred percent of the full cost of HIP-Blue Cross on a category basis." At the time, HIP-Blue Cross was offered to both employees and retirees, but in 1966 the plan had stopped providing benefits that retirees could receive through Medicare. Section 12-126's threshold "on a category basis" must be interpreted against this backdrop.

ples-to-apples comparison to base the law's monetary cap for Medicare-eligible individuals on the cost of HIP HMO coverage for non-Medicare-eligible individuals. To the contrary, that approach would violate the law's express requirement that the cap must be assessed "on a category basis."[15]

Nor would the approach make sense. After all, the City's residents pay taxes to the federal government—and thus fund Medicare—as well as paying taxes to state and city governments. In fact, New York taxpayers are typically net donors who pay more in federal taxes than they receive in return in federal benefits.[16] Again, when it enacted § 12-126, the City Council recognized that healthcare coverage for Medicare-eligible individuals could be pred-

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[15] Nor can the applicable cap be based on the cost of Senior Care, which is not an HMO at all (R148, 151). While the City has historically agreed as a matter of collective bargaining to pay the cost of Senior Care (and to pay for other plans up to that cost), the cost of Senior Care is not relevant to the legal obligation established by § 12-126.

[16] Office of the N.Y.S. Comptroller, *New York's Balance of Payments in the Federal Budget: Federal Fiscal Year 2019*, at 5 (2020), *available at* https://perma.cc/445R-ZKFV (last visited Mar. 20, 2022) (in total dollars, New York's gap between federal taxes paid and spending received was largest among all 50 states).

icated on Medicare enrollment, and included a special provision requiring the City to reimburse Medicare Part B premiums for such individuals. It stands to reason that the Council would have expected the monetary cap on the City's other payment obligations to be appropriately adjusted for that category of insured—so as to account for the federal Medicare subsidies that city taxpayers likewise pay to fund.

The City continues to offer HIP HMOs,[17] and it is these plans that form the baseline for the current statutory threshold. As they have since the 1960s, the plan for retirees (HIP VIP HMO) still relies on Medicare to provide coverage, resulting in dramatically lower premiums than the plan for active employees (HIP HMO Preferred). To use any other threshold would contradict the law's text,

[17] Contrary to petitioners' claim below, HIP VIP HMO is still offered to Medicare-eligible retirees and will continue to exist after MAPP's implementation. N.Y.C. Office of Labor Relations, *Retiree Health Plan Rates as of April 1, 2022* (2022), *available at* https://perma.cc/A6WE-UBPD (last visited Mar. 20, 2022).

structure, and legislative history, and force the City's residents to pay twice for benefits that Medicare already provides.[18]

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For all of the reasons given here, § 12-126's mandate is satisfied by providing a cost-free plan to Medicare-eligible retirees up to the cost of HIP VIP HMO. MAPP is just such a plan and, although the City is free to provide more than the law requires—as it often has through collective bargaining—§ 12-126 does not limit the City's flexibility to respond to changing economic circumstances while still offering retirees superior healthcare at no cost. And, even if the Court were to conclude that § 12-126 requires the City to pay for any below-cap plans that are made available—rather than simply to provide at least one cost-free plan—the law's monetary cap equals the cost of HIP VIP HMO, which the cost of Senior Care and more expensive plans exceed.

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[18] EmblemHealth recently lowered HIP VIP HMO's costs even further so that the plan could compete with the premium-free MAPP. Of course, that was EmblemHealth's choice to make based on its judgments about how best to succeed in a competitive market.

CONCLUSION

The Court should vacate the order below and deny the petition in its entirety.

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March 21, 2022

Respectfully submitted,

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